

Applying emotion-focused therapy to work with the ‘anorexic voice’ within anorexia
nervosa: a brief intervention.

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Executive Summary

The Systematic Review

Background.

- Processing problematic emotions is thought to be a central mechanism of change across various psychotherapeutic approaches.
- Emotion-focused therapy (EFT) is a therapeutic approach designed to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions and change maladaptive emotions.
- Chairwork techniques are applied in emotion-focused therapy (EFT) and are thought to enhance emotional processing.
- EFT typically utilises three distinct types of chairwork: two-chair dialogues for self-evaluative splits (in which one aspect of the self is critical or coercive towards another aspect), two-chair enactments for self-interruptive processes, (when one part of the self interrupts or constricts emotional experience and expression), and empty-chair dialogues for unresolved feelings towards a significant other.
- In two-chair work, an individual moves between chairs representing different perspectives or parts of the self.
- In empty-chair dialogues, the client speaks with an ‘other’ who is imagined in the empty chair.
- Different chairwork techniques are applied in response to specific client experiences or behaviours that naturally emerge in therapy.

- EFT appears to be a clinically effective form of psychotherapy but it is not yet known to what extent outcomes are attributable to specific chairwork interventions, or ‘non-specific factors’ such as the therapeutic relationship.

Purpose of the review.

- The purpose of the systematic literature review was to determine the effectiveness of emotion-focused chairwork interventions in reducing symptoms of psychological distress in adults.

Brief details of the method.

- A systematic review of English articles published in peer reviewed journals using PsychInfo, PubMed, and PsycArticles was performed.
- Search terms included ‘emotion-focused therapy’, ‘process experiential therapy’, ‘chairwork’, ‘chair-based’, ‘empty-chair’, ‘two-chair’, ‘unfinished business’ and ‘gestalt’.
- Only Randomised Controlled Trials (RCTs) or Quasi-Experimental Designs (QEDs) of emotion-focused chair-based interventions that examined improvements in psychological distress quantitatively, with at least baseline-to-post implementation assessment design, were included.
- Eligibility assessment was performed independently in a standardised manner by the first author.

Important results and findings.

- A total of 12 studies were identified for inclusion in the review (seven RCTs and five QEDs).
- Although a small number of studies in total, several interventions were found to improve psychological distress post-intervention for clients with depression,

anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse.

- Moreover, where reported, these changes appear to be sustainable over time.
- The efficacy of chairwork can be more reliably implicated as the active ingredient in studies where EFT with chairwork was compared with EFT without chairwork or a cognitive intervention, or chairwork was evaluated as a stand-alone intervention.
- Effects are a little less clear when EFT was compared against psychotherapies other than person-centred therapy as outcomes could be linked to interventions other than emotion-focused chairwork. For example, those studies that favoured EFT over CBT, waiting lists and psychoeducational groups might relate to elements of EFT other than chairwork (e.g. the therapeutic relationship).

Limitations at study and outcome level.

- Quasi-experimental designs provide limited information about treatment effectiveness due to lack of control for alternative explanations.
- All studies relied solely on self-report instruments to assess outcome.
- Many studies reported low sample size as a major limitation to generalisability.
- The studies employed a variety of emotion-focused chairwork interventions for a variety of problems and moreover, it was not always clear what or how much of the intervention was being used. Therefore, it is difficult to merge the findings and identify precisely what is differentially effective.

- Unfortunately, it was beyond the scope of this review to examine mechanisms of change. It would be useful to provide evidence that the process hypothesised to be affected by the intervention actually changed and can be linked to mental health.

Limitations at review level.

- The results are based solely on published studies so there may be a publication bias.
- Only studies that were written in English were included in the review which may have excluded potentially important studies.
- The robustness of the findings is severely limited by the number and size of the studies in this relatively novel field of research.
- The variety of psychological problems examined and heterogeneity in outcome and design meant that a meta-analysis was not possible.

Major conclusions.

- Overall, the findings provide tentative evidence that emotion-focused chair-based interventions might alleviate psychological distress in individuals with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse.
- However, because of the small number of studies, the even smaller number of RCTs, and the heterogeneity of interventions, outcomes and measures, existing data on emotion-focused chair-based interventions to address psychological illness in adults cannot yet support definitive conclusions.
- More work is needed to:

- 1) Address the extent to which the chairwork techniques are responsible for improvement in outcomes
- 2) Establish who responds best to these interventions
- 3) Determine whether and how chairwork is effective for disorders other than those included in this review.

The Empirical Study

Background.

- Anorexia nervosa (AN) is a difficult disorder to treat and there is a lack of clear evidence for effective therapies.
- One of the main challenges in treating individuals with AN is that they are often ambivalent about engaging in treatment.
- Accordingly, there is a demand to develop new approaches for the treatment of adults with AN which both better engage clients and explain how and why symptoms are maintained.
- Qualitative research has identified the experience of an ‘anorexic voice’ (AV) in individuals with anorexia nervosa (AN).
- The AV is an internally generated, but distinct, second or third person commentary on thoughts and behaviours relating to eating, weight and shape.
- It has been hypothesised to contribute to the development and maintenance of AN and provides an interesting formulation of the many challenges encountered in work with this clinical group (such as the egosyntonic nature of the illness).
- Emotions have been demonstrated to play an important role in the development and maintenance of AN.

- Maintenance models of AN hypothesise that engaging in ED behaviours helps to avoid or suppress negative emotions.
- EFT has been considered for the treatment of EDs as this approach involves processing emotional experience in order to deal with difficulties in affect regulation, thus rendering AN as unnecessary in coping with negative emotions.
- It also offers techniques (e.g. the two-chair dialogue for self-evaluative splits) for dealing explicitly with the AV.
- It was theorised that working with the AV would increase emotional awareness and/or help clients to cope with and manage emotions in more adaptive ways.

Purpose of the report.

- The overall aim of the present study was to examine whether a brief form of EFT that focuses on the AV (EFT-AV) is feasible and acceptable as an intervention for adults with AN, presenting to outpatient ED services.
- The study was exploratory and aimed to answer the following research questions:
- Is EFT-AV a feasible intervention for adults with AN who present to outpatient ED services?
- Do participant's evaluations of the intervention indicate that it is considered an acceptable treatment?
- Can EFT-AV lead to improvements in: a) the relationship with the AV; b) illness beliefs; c) ED cognitions and behaviours and d) motivation to change and hope of recovery?

Brief details of the method.

- The study employed a single-case experimental design (SCED).
- Six clients diagnosed with AN who were experiencing an AV and on a waiting list for psychological treatment for their ED were recruited from an adult outpatient ED service.
- The intervention itself involved six, weekly, individual one hour sessions.
- The treatment manual was designed by the research team, applying the general principles of EFT to working with the AV.
- I served as the therapist in the study and before starting the intervention, I participated in basic EFT training, facilitated by my supervisors, totalling approximately 30 hours.
- To reduce threats to the study's validity, my competency to deliver the intervention was measured.
- Participants completed standardised weekly measures of symptomatology, as well as measures of the relationship with the AV, illness beliefs and pre- and post-intervention measures of motivation to change and hope of recovery.
- One week post-intervention I conducted follow-up face-to-face interviews with the participants.

Important results and findings.

- Recruitment, retention and treatment adherence provided encouraging support for the feasibility of the intervention.
- Thematic analysis of participant follow-up interviews demonstrated that the intervention was considered acceptable by participants.

- The study was only designed to test the intervention in a limited way. However, visual analyses of weekly measures showed that relative to baseline, the extent to which all participants identified with, endorsed and experienced the AV decreased from baseline to intervention and that this continued to decrease over the course of the intervention.
- In addition, one participant showed an improvement in eating disorder behaviour and cognitions and two participants indicated a less threatening view of the illness over the course of the intervention.
- Trends were also indicated for increased motivation to change and hope of recovery.
- Three out of four participants did not show any change in ED behaviour and cognitions and two out of four participants did not show any change in their beliefs about the illness.
- The results from the quantitative part of this study indicate that participants can tolerate the intervention without exacerbating symptoms, which was encouraging.

Limitations.

- The generalisability of the effects of the intervention is limited by the small number of participants treated and the single recruitment site.
- The outcome of treatment relied upon self-report measures that were handed to me upon completion, thus lacking objective and independent clinician-administered assessment.
- The delivery of treatment relied on one therapist, who was also the Chief Investigator (CI) for the study. This is problematic for two reasons. First,

though I had approximately 30 hours of basic EFT training, I had not delivered EFT before in a clinical setting. Secondly, experimenter bias could have limited the reliability of the study measurements.

- The measurement of treatment fidelity was also subject to bias, since although all of the audio recordings were rated, one of the raters was the CI who carried out the intervention.

Major conclusions.

- Overall this study provides new but tentative evidence highlighting the potential of brief EFT that focuses on the AV as a feasible and acceptable intervention for some adults with AN.
- This study adds to the growing literature implicating the need for treatment approaches to incorporate this phenomenological aspect of AN.
- The intervention now warrants further evaluations in a pilot study to substantiate its results, identify treatment effects, and the conditions under which the intervention will be optimally effective.

Integration

- The review provided a conceptual basis for the empirical study as it highlighted the potential of emotion-focused chairwork techniques for alleviating psychological distress in clients with a variety of mental health difficulties.
- Moreover, the small number of studies included in the review revealed the lack of empirical investigations of emotion-focused chairwork techniques.

- There were no studies that included a clinical sample of people with EDs which indicated a gap in the literature – to determine whether and how chairwork is effective for people with EDs.
- Research challenges such as recruitment difficulties and researcher bias shifted what was understood to be realistic goals for the project.

Impact

- The findings from the literature review and results of the empirical study offer a contribution to the literature, in under-researched areas.
- In response to growing appeals for novel models of pathology which better engage clients and explain the persistence of EDs, the finding that brief EFT-AV is both feasible and acceptable suggests that the AV is a phenomenon worthy of further investigation, both in terms of improving understandings of how AN is maintained and facilitating the development of novel interventions for AN that incorporate work with the AV.
- Trends from the empirical study suggest that motivation to change and hope of recovery might improve over the course of a brief EFT-AV intervention. If this finding is substantiated in larger pilot studies or RCTs, it could indicate that EFT-AV should be used as a modular intervention, either as a preventative ‘top up’ intervention for relapsing/treatment-resistant individuals, or even as part of a pre-intervention where a focus on client’s motivation to change is required before commencing a ‘change-focused treatment (e.g. CBT).
- Findings from the systematic review inform on the empirical foundation and specification of chair-based interventions.

- Results from studies where EFT with chairwork was compared with person-centred therapy or empathic exploration, or when chairwork was evaluated as a stand-alone intervention and compared against a more cognitive intervention suggest that chairwork is the active ingredient in emotion-focused interventions.
- This has implications for the delivery of emotion-focused therapy.

Dissemination

- Work is currently underway to submit the empirical study for peer review at the 'Journal of Consulting and Clinical Psychology' and to submit the systematic review for peer review at 'Clinical Psychology Review'.

Systematic Review

Abstract

Chairwork techniques (such as two-chair dialogues for self-evaluative and self-interruptive splits and empty-chair dialogues for unresolved feelings towards a significant other) are applied in emotion-focused therapy (EFT) and are thought to enhance emotional processing. EFT appears to be a clinically effective form of psychotherapy but it is not yet known to what extent outcomes are attributable to specific chairwork interventions. The purpose of this review was to determine the effectiveness of emotion-focused chairwork interventions in reducing symptoms of psychological distress in adults. A systematic review of English articles published in peer reviewed journals using PsychInfo, PubMed, and PsycArticles was performed. Search terms included ‘emotion-focused therapy’, ‘process experiential therapy’, ‘chairwork’, ‘chair-based’, ‘empty-chair’, ‘two-chair’, ‘unfinished business’ and ‘gestalt’. Only Randomised Controlled Trials (RCTs) or Quasi-Experimental Designs (QEDs) of emotion-focused chair-based interventions that examined improvements in psychological distress quantitatively, with at least baseline-to-post implementation assessment design, were included. Study selection was conducted by the first author. Seven RCTs and five QEDs met the inclusion criteria. Emotion-focused chair-based interventions improved psychological distress post-intervention for clients with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse. Moreover, where reported, these changes appeared to be sustainable over time. However, because of the small number of studies, the even smaller number of RCTs, and the heterogeneity of interventions, outcomes and measures, existing data on emotion-focused chair-based

interventions to address psychological illness in adults cannot yet support definitive conclusions.

The clinical effectiveness of emotion-focused chair-based interventions for adults
with mental health difficulties: a systematic review.

Introduction

An increasing amount of research suggests that working with emotions is integral in alleviating the symptoms of psychological distress (Foa, Huppert, & Cahill, 2006; Pos, Greenberg, Goldman, & Korman, 2003; Whelton, 2004). Moreover, processing problematic emotions is thought to be a central mechanism of change across various psychotherapeutic approaches (e.g. exposure [Rachman, 1980] and catharsis [Breuer & Freud, 1974]; Castonguay & Hill, 2012; Diener, Hilsenroth, & Weinberger, 2007; Norcross & Wampold, 2011).

Emotion-focused therapy (EFT) is a therapeutic approach designed to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions and change maladaptive emotions (Greenberg, 2011). EFT combines person-centred relational principles (Rogers, 1961) with more directive evocative interventions (derived from gestalt and experiential therapies) that are thought to intensify emotional processing. After building a strong relational foundation (using empathic responding, genuineness, unconditional positive regard, Rogers, 1961), emotion-focused therapists employ various experiential interventions, such as focusing (Gendlin, 1996), systematic evocative unfolding (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993) and chair-based enactments, commonly referred to as ‘chairwork’ (Perls, Hefferline, & Goodman, 1951).

Chairwork

Chairwork techniques have been used in various ways, across various therapeutic modalities. Kellogg (2012, 2015) differentiates between two core forms of chairwork. ‘Internal dialogues’ allow the client to speak to different parts of the self, while ‘external dialogues’ enable the client to give voice to significant others in order to resolve ‘unfinished business’. In addition, chairwork techniques tend to facilitate two types of dialogue. ‘Exploratory’ chairwork exercises are used to ascertain emotional states and coping responses (Kellogg, 2015; Pugh, 2017a), whereas ‘directed’ chairwork dialogues target specified outcomes such as the resolution of internal conflicts (Pugh & Rae, 2018). Lastly, in line with relational frame theory (Hayes, Strosahl, & Wilson, 2011), various therapeutic perspectives or ‘frames’ (e.g. ‘interpersonal’, ‘intrapersonal’ or ‘temporal’) are enabled through chairwork (Pugh & Rae, 2018).

The gestalt approach was the first to apply chairwork within one-to-one therapy (Perls, Hefferline, & Goodman, 1951). Gestalt therapy focuses on the client as a whole, interconnected with their environment, relationships and experiences. Emphasis is placed on the here and now, rather than what was, might be, or should be. The goal of gestalt therapy is to help the client to become aware of what they are doing and how they are doing it. Then, it helps the client see how they can change, while also learning to accept and value themselves. The empty chair is used to allow the client to work through interpersonal or internal conflict, to help the client see the situation from a different perspective and gain insight into their feelings and behaviours.

Gestalt therapy and its techniques have been widely used and incorporated into various therapies since its inception in the 1940s. For example, schema therapy, which combines techniques drawn from cognitive, behavioural, gestalt and psychoanalytic therapies (Young, Klosko, & Weishaar, 2003), regards chairwork as a core experiential intervention. In schema therapy, chairwork is used to modify trait-like maladaptive schemas and heal state-like schema 'modes' (Young, Klosko, & Weishaar, 2003). When modifying early maladaptive schemas through chairwork, the schema is typically stated in one chair and counter-evidence is presented from the other. These are known as 'schema dialogues' (Young, Klosko, & Weishaar, 2003). When healing state-like schema 'modes', chairwork techniques are used to strengthen the healthy adult 'mode', heal vulnerable child modes, minimise maladaptive coping modes, and challenge dysfunctional parent modes (Arntz & Jacob, 2013). Chairwork typically begins with the therapist (enacting the healthy adult mode) confronting the mode which is placed in an empty chair. As therapy progresses, the client is encouraged to adopt the healthy adult role. Schema therapy is somewhat unique in using many chairs simultaneously. Complex mode-focused dialogues using four or more chairs are not uncommon in this approach (Arntz & Jacob, 2013).

In cognitive behaviour therapy (CBT) the aim is to restructure problematic cognitions and galvanise adjustments in behaviour (Pugh, 2017a). When restructuring cognition through chairwork, a two-chair format is typically used where one chair represents the evidence for a thought or belief, and a second which represents disconfirmatory evidence (Pugh, 2017a). The empty chair technique is also used in cognitive restructuring where a negative belief is placed in an empty chair and is challenged by the therapist and/or client. Finally, two chair interventions can be used

to test the accuracy of beliefs where an ambivalent client is asked to speak from chairs which represent the advantages (chair one) and disadvantages (chair two) of particular beliefs and behaviours (Pugh, 2017a). When cementing behaviour change through chairwork new behavioural strategies are typically elaborated and practiced through chairwork roleplay (Dancu & Foa, 1992).

Emotion-focused chair-based techniques can be distinguished from chair-based techniques used in other psychotherapies. Chairwork techniques in EFT are designed to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions and change maladaptive emotions (Greenberg, 2008). Task and conversational analysis studies have helped identify the key processes and procedures hypothesised to be associated with the resolution of distress in emotion-focused forms of chairwork (Greenberg, 1983; Greenberg & Webster, 1982; Sutherland, Perakyla, & Elliott, 2014).

Forms of Emotion-Focused Chairwork

EFT typically utilises three distinct types of chairwork: two-chair dialogues for self-evaluative splits (in which one aspect of the self is critical or coercive towards another aspect), two-chair enactments for self-interruptive processes, (when one part of the self interrupts or constricts emotional experience and expression), and empty-chair dialogues for unresolved feelings towards a significant other (Greenberg, 2008; Greenberg, 2010; Greenberg, 2011). In two-chair work, an individual moves between chairs representing different perspectives or parts of the self. In empty-chair dialogues, the client speaks with an ‘other’ who is imagined in the empty chair. Different chairwork techniques are applied in response to specific client experiences or behaviours that naturally emerge in therapy.

Two-chair work for self-criticism. Two-chair dialogues are assumed to reduce self-criticism by facilitating integration and negotiation between critical and criticised parts of the self (Greenberg, 1979). First, an individual moves between two chairs, embodying the inner critic in one chair and responding to it in the other. Throughout the intervention, the individual is encouraged to focus on how it feels to be attacked by their inner critic (Stiegler, Molde, & Schanche, 2017). This process is repeated several times, before the client is invited to express what they need from their critical voice. This usually has one of two outcomes for the client: either they assert themselves against the critic with anger, or there is an outburst of sadness and appeal for support (Pugh, 2017b). Returning to the critical chair, the inner critic either continues to attack the client (in which case the client is encouraged to stay assertive [Greenberg, 2011]) or the critic ‘softens’ and a more compassionate form of self-to-self relating is generated (Greenberg 1979).

Two-chair work for self-interruption. In comparison to self-evaluative splits, “self-interruptive splits have a larger non-verbal, bodily aspect and are sometimes expressed in an entirely nonverbal manner, such as a sudden headache or choking sensation” (Elliott, Watson, Goldman, Greenberg, 2004, p.237). In two-chair work, the interrupting part of the self is exposed (either physically, metaphorically or verbally) and the individual is encouraged to respond to and challenge the interruptive parts of the self. In becoming aware of their self-interruptions, clients learn how they are blocking their emotions and the consequences in terms of depression, guilt, anxiety or physical pain. They also learn that they have the power to change those feelings and develop a sense of agency and control. Resolution occurs when the client expresses the previously blocked experience (Elliott et al., 2004).

Empty-chair dialogues for lingering feelings. The empty-chair task for unfinished business (Perls et al., 1951) is used for two types of unfinished business: neglect or abandonment and abuse or trauma. For attachment-based relationship difficulties, the empty-chair dialogue is designed to facilitate processing, transforming and the resolution of lingering feelings towards specific individuals (Paivio & Greenberg, 1995). The client imagines the significant other in an empty seat and engages in a dialogue with them, sharing previously unexpressed emotions (such as hurt and anger). Resolution involves holding the other accountable or understanding or forgiving the other. In this way, the empty-chair task enables clients to resolve past losses, hurts, and anger toward significant others by encouraging the identification, expression and processing of unresolved feelings and associated needs (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002).

Empty-chair dialogue for abuse or trauma. In contrast to empty-chair interventions for unresolved feelings, empty-chair interventions for abuse or trauma focuses on justice for the violation. The client is invited to talk about the abuse or trauma and to imagine the abuser in an empty chair. They are encouraged to notice their internal experience and to verbalise their thoughts and feelings about the abuse or trauma directly to the imagined other (Paivio & Nieuwenhuis, 2001). This process involves retrieving maladaptive aspects of the memory or meaning system (such as fear, insecurity and shame) and eliciting previously suppressed adaptive emotional responses, such as anger and sadness. In this way, the new adaptive information can be used to modify meaning. For example, anger at the violation is thought to nurture a sense of empowerment and promote assertive behaviour. Likewise, an outpouring of sadness allows the client to grieve, accept the loss, and access self-soothing resources

that help the individual cope with the emotional pain (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010).

Two-chair work for decisional conflict. The two-chair dialogue has also been used to resolve intrapersonal conflicts such as ambivalence and uncertainty about decisions (Greenberg, 1983; Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981). The client is asked to change chairs, facilitating a dialogue between two sides of a conflict (Greenberg & Webster, 1982). Integration of the opposing parts into a new set of responses to the situation is assumed to lead to an integration and conflict resolution (Perls, 1973).

Two-chair work for self-soothing. Finally, the two-chair technique has been used to elicit ‘compassionate self-soothing’ (Goldman & Greenberg, 2010; Sutherland et al., 2014). Conceptually, self-soothing works by eliciting the emotional pain that underlies the self-critical or unresolved experiences and then helping the client to access alternative, self-supporting internal resources. This is achieved by asking the client to change chairs, alternating between a ‘soothing other’ (which might include, for example, enacting individuals who have offered care and support in the past) and the soothed-self (Goldman & Greenberg, 2013).

Rationale for the Review

EFT is recognised as an evidence-based treatment for depression and trauma (Courtois & Ford, 2009; Ellison, Greenberg, Goldman, & Angus, 2009; Goldman, Greenberg, & Angus, 2006; Greenberg, 2010; Paivio et al., 2010) and it has shown promise for anxiety disorders (Cisler, Olatunji, Feldner, & Forsyth, 2010; Greenberg, 2010; MacLeod, Elliott, & Rodgers, 2012; Shahar, Bar-Kalifa, & Alon, 2017). In addition, the outcome of EFT has also shown to be effective with various other client

difficulties, such as decisional conflicts (Clarke & Greenberg, 1986, Greenberg & Webster, 1982) and interpersonal difficulties (Greenberg, Warwar & Malcolm, 2008; Paivio & Greenberg, 1995).

Whilst EFT appears to be a clinically effective form of psychotherapy, it is not yet known whether these outcomes are attributable to its active and process-driven interventions such as chairwork, or ‘non-specific factors’ such as the therapeutic relationship. According to a narrative review of chairwork in CBT, “there exists sufficient evidence to hypothesise that chairwork is a versatile and powerful therapeutic technique” (Pugh, 2017a, pp. 27). The author concludes that within CBT, chairwork is a valuable tool for assessment, cognitive and behavioural modification, emotional transformation and measurement of treatment outcome (Pugh, 2017a). However, these conclusions are speculative, given the paucity of quantitative research looking at chairwork in CBT. Moreover, the same conclusions are yet to be projected to the use of chairwork interventions within EFT. For example, Elliott, Greenberg and Lietaer (2003) reported large effect sizes for client outcomes from EFT interventions but the studies included in their meta-analysis involved a variety of forms of EFT, with varying degrees of chairwork input. Moreover, the specification and frequency of chairwork input and the level of training and supervision of treating clinicians was not always clearly documented. In addition, overall effect sizes were calculated by averaging all of the outcome measures from each study, so conclusions cannot be inferred regarding what is effective for whom. Finally, the majority of the studies in their review were carried out by strong supporters of EFT, so the results may reflect research allegiance effects.

Ambiguity in the literature around definitions of EFT further contributes to the current challenges in establishing the effectiveness of emotion-focused chair-based interventions. Process-experiential therapy (PET; Greenberg et al., 1993) and EFT are often described interchangeably and inconsistently in the literature. Elliott and Freire (2008) published a meta-analysis on ‘person-centred/experiential therapies’ with anxiety difficulties, but without consistent definitions it is difficult to determine the relevance of this study for establishing the clinical effectiveness of chairwork techniques in EFT.

With this in mind, the following systematic review aims to assess the clinical effectiveness of emotion-focused chair-based treatments, informing on empirical foundation and specification of interventions. On the basis of the existing theoretical and empirical foundation of EFT and emotion-focused chairwork techniques, it was hypothesised that, among empirical studies that directly target improvements in adult mental health, emotion-focused chair-based interventions will be effective in reducing symptoms of psychological distress.

Methods

Eligibility Criteria

Where appropriate, the systematic review was conducted according to the “Preferred Reporting Items for Systematic Reviews and Meta-Analyses” (PRISMA) statement (Moher, Liberati, Tetzlaff, Altman, & Group, 2009). Studies were selected based on the following criteria (a) adult participants of any age; (b) Randomised Controlled Trials (RCTs) comparing the effectiveness of emotion-focused chairwork techniques with wait-list controls or a comparative intervention; (c) studies that employed a quasi-experimental design (QED) to examine the effects of an emotion-

focused, chair-based intervention with at least baseline-to-post implementation assessment design; (d) primary outcomes targeted improvements in symptoms of psychological distress. After meeting these criteria, studies that utilised quantitative measurement rather than qualitative report of mental health outcomes were included. The search was limited to studies presented in English in peer-reviewed journals. There were no restrictions placed on the year of publication.

Information Sources

Studies were identified by searching electronic databases, manual reviews of reference lists of articles, and consultation with experts in the field. This search was applied to PsycINFO (1970 - Present); PubMed (1970 - Present); and PsycARTICLES (1970 - Present). The last search was run on 25 January 2018.

Search

Key word search terms included in the search were: EMOTION FOCUSED THERAPY [OR] EFT [OR] PROCESS EXPERIENTIAL THERAPY [OR] PET [OR] EXPERIENTIAL THERAPY [AND] CHAIR WORK [OR] CHAIR [OR] CHAIRWORK [OR] EMPTY CHAIR [OR] TWO CHAIR [OR] TWO CHAIR TECHNIQUE [OR] CHAIR BASED EXERCISE [OR] UNFINISHED BUSINESS [OR] GESTALT.

Study Selection

Eligibility assessment was performed by the first author. Articles sourced from the initial search were screened by the content of their abstracts and then relevant manuscripts retrieved. Full text articles were then assessed further for suitability (see Figure 1 for CONSORT diagram of study selection).

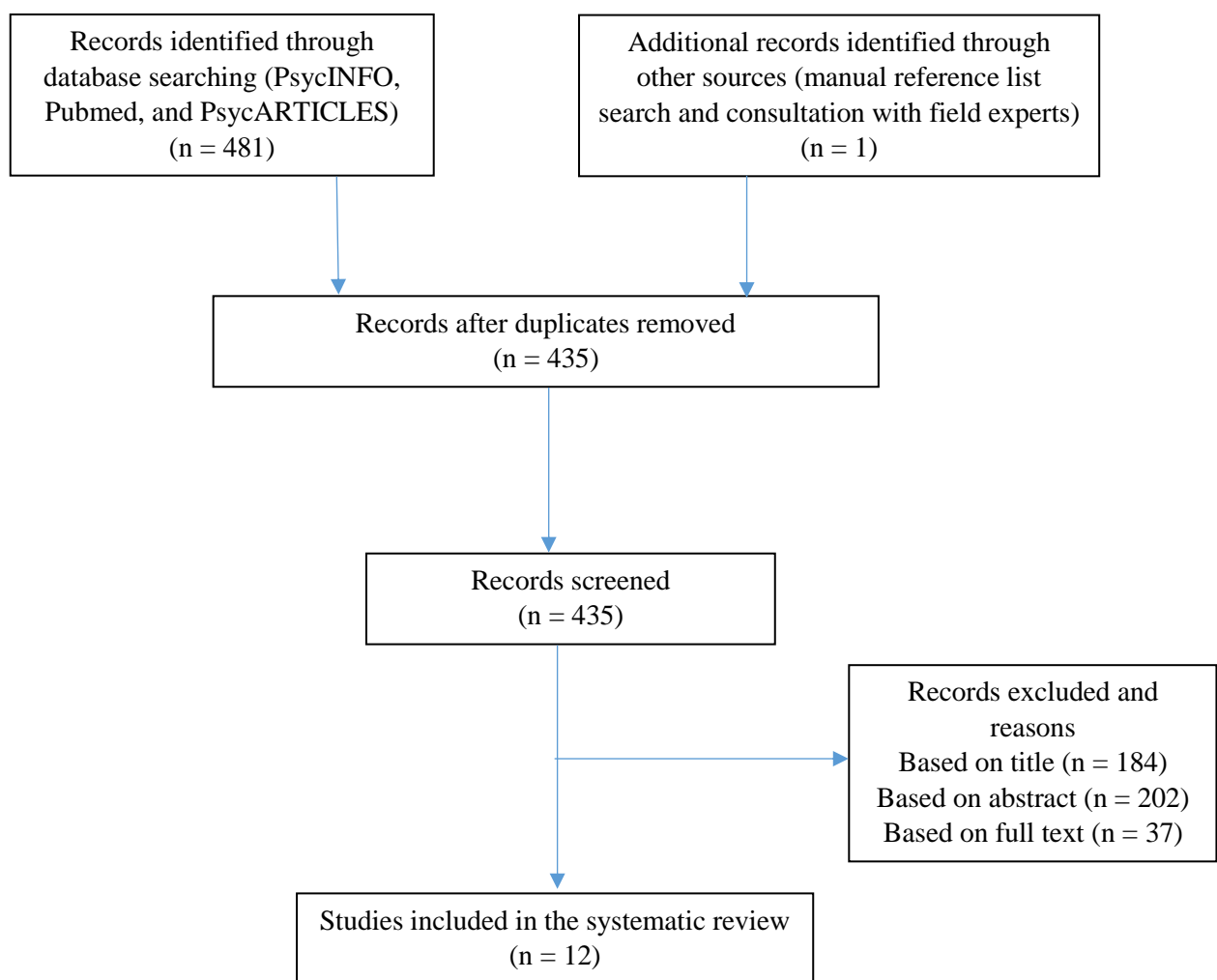


Figure 1: Flow diagram of study search selection

Data Extraction

A data extraction sheet was developed (based on the Cochrane Consumers and Communication Review Group's data extraction template), pilot-tested on four randomly-selected included studies, and refined accordingly. The following data were extracted from the included studies. One author was contacted for further information that was not available in the published article.

Data Items

Information was extracted from each included trial in regard to (a) characteristics of trial participants (including age, gender, ethnicity, psychological distress); (b) sample formations (including inclusion and exclusion criteria and recruitment method); (c) type of intervention (including format, setting, duration, frequency and comparison interventions where applicable; (d) type of outcome measure (including level of symptom reduction, improvement in psychological well-being, measurement points and length of follow up where applicable).

Risk of Bias in Individual Studies

To ascertain the validity of eligible trials, a quality assessment tool was developed (based on the Effective Public Health Practice Project's Quality Assessment Tool for Quantitative Studies). The tool was used to assess sample representation, the presence and adequacy of randomisation, blinding of participants, data collectors and outcome assessors, confounding variables and extent of loss to follow-up (i.e. proportion of participants in whom the investigators were not able to ascertain outcomes). To explore variability in study results (heterogeneity), the following hypotheses were specified before conducting the analysis (a) treatment

effect may differ according to the methodological quality of the studies; (b) study reliability will be affected by the methodological quality of study.

Summary Measures

To evaluate treatment effects across RCTs, effect sizes will be reported or computed. Cohen's effect sizes are understood as negligible (≥ -0.15 and < 0.15), small (≥ 0.15 and < 0.40), medium (≥ 0.40 and < 0.75), large (≥ 0.75 and > 1.10), very large (≥ 1.10 and < 1.45) and huge (≥ 1.45) (Cohen, 1988). Because QEDs do not adequately control for extraneous variables and alternate explanations of the treatment effect (Harris, et al., 2006) resultant effect sizes might be overestimated (Shadish, Robinson, & Lu, 1999). Therefore, significance testing will be used to evaluate treatment effects for QEDs. An analysis of treatment effect will examine results for RCTs and QEDs separately.

Results

Study Selection

A total of 12 studies were identified for inclusion in the review. The search of PsychINFO, PubMed and PsycARTICLES databases provided a total of 481 citations. An additional 20 studies were identified by checking the references of relevant papers, searching for studies that have cited these papers, and through consultation with experts in the field. After adjusting for duplicates, 435 articles remained. Of these, 184 were discarded based on their titles and a further 202 were discarded due to not fulfilling the review criteria on the basis of information provided in the abstract. The full texts of the remaining 49 citations were examined in more detail, following which 37 studies did not meet the inclusion criteria as described. Twelve studies met

the inclusion criteria and were included in the systematic review. See flow diagram in Figure 1.

Study Characteristics

Participants.

Characteristics. Characteristics of participants are detailed in Table 1. In summary, female participants widely outnumbered male participants. In studies that reported mean age, the range of participants' mean age was 26.75 to 46.4 years. Where ethnicity was reported, the study samples consisted predominantly of Caucasian/Europeans ($M = 92\%$). However, ethnicity was not reported in six out of the 12 studies.

Sample formation. Studies used a variety of recruitment methods and eligibility criteria in the formation of study samples. Commonly imposed exclusion criteria included (a) currently in treatment or on medication; (b) current diagnosis of bipolar disorder, panic disorder, substance dependence, eating disorder, psychotic disorder, two or more schizotypal features, paranoid, borderline or antisocial personality disorders; (c) loss of a significant other in the last year; (d) currently involved in a physically abusive relationship; (e) abusing drugs or alcohol. Recruitment methods ranged from advertisements posted in the community, email, newspaper and radio announcements in educational settings and promotion in mental health clinics.

Table 1: Descriptive characteristics of mental health interventions

Study	Intervention description/setting	Participants	Research design	Outcomes / pre-post ES (for RCTs) or significance (for QEDs) in the EFT condition	Control or comparison condition	Difference in ES	Pre-follow-up (time) significance
Depression							
Goldman et al. (2006)	EFT with two chair and empty chair dialogues Location: Canada Duration: 16 - 20 weeks (60 min per week)	$n = 38$ (Females = 24; Males = 14) Clients meeting diagnostic criteria for major depressive disorder Age: $M = 39.5$ Ethnicity: European (89%); Asian (5%); Latino (3%); Caribbean Canadian (3%)	RCT	BDI / 2.99 SCL / 2.4 IIP / 0.95 RSE / 1.21	Client-centred therapy	BDI / 0.76 SCL / 1.24 IIP / 0.42 RSE / 0.4	—
Greenberg and Watson (1998)	EFT with two chair and empty chair dialogues Setting: Canada Duration: 15-20 weeks (60 min per week)	$n = 34$ (Females = 25; Males = 9) Clients meeting diagnostic criteria for major depressive disorder: Age: $M = 39.64$ Ethnicity: not specified	RCT	BDI / 2.82 SCL / 3.03 IIP / 2.4 RSE / 1.39	Client-centred therapy	BDI / 0.22 SCL / 0.56 IIP / 1.15 RSE / 0.66	BDI / nr (6m) SCL / nr (6m) IIP / nr (6m) RSE / nr (6m)
Robinson et al. (2014)	Group EFT with chairwork Setting: Canada Duration: 9 weeks (120 min per week)	$n = 8$ Adults referred for anxiety and depression Age: $M = 41.5$ Ethnicity: not specified	QED	BDI / ns BAI / ns DERS / 0.06	—	—	BDI / nr (12m) BAI / nr (12m) DERS / nr (12m)
Watson et al. (2003)	EFT with two chair and empty chair dialogues Location: Canada Duration: 16 weeks (60 min per week)	$n = 66$ (Females = 44; Males = 22) Clients meeting criteria for major depressive disorder Age: $M = 41.52$ Ethnicity: European (91%), Asian (6%), Hispanic (3%)	RCT	BDI / 1.73 SCL / 0.69 IIP / 0.74 RSE / 0.89	Cognitive behavioural therapy	BDI / 0.14 SCL / 0.05 IIP / 0.44 RSE / 0.21	—

Abuse and trauma							
Paivio and Nieuwenhuis (2001)	EFT with empty chair dialogue Location: Canada Duration: 20 weeks (60 min per week)	<i>n</i> = 46 (Females = 39; Males = 7) Adult survivors of childhood abuse Age: <i>M</i> = 38 Ethnicity: Caucasian (92%), Aboriginal (6%), Asian (2%)	QED	SASB-A / <0.001 SASB-C / ns RS / <0.001 IIP / <0.01 IES / <0.01 SCL / <0.01	Wait-list control	SASB-A / <0.001 SASB-C / ns RS / <0.001 IIP / <0.01 IES / <0.001 SCL / <0.01	SASB-A / <0.001 (9m) SASB-C / ns (9m) RS / <0.001 (9m) IIP / <0.001 (9m) IES / <0.001 (9m) SCL / <0.001 (9m)
Paivio et al. (2010)	EFT with empty chair dialogue Location: Canada Duration: 16-20 weeks (60 min per week)	<i>n</i> = 45 (Females = 24; Males = 21) Adult survivors of childhood abuse Age: <i>M</i> = 45.62 Ethnicity: European (89%); Other (11%)	RCT	IES / 1.56 STAXI / 1.18 BDI / 1.56 IIP / 0.96 RS / 1.84 RSE / 0.96	EFT with empathic exploration	IES / -0.32 STAXI / 0.44 BDI / 0.61 IIP / 1.12 RS / 0.91 RSE / 0.45	IES / <0.05 (12m) STAXI / <0.05 (12m) BDI / <0.05 (12m) IIP / <0.05 (12m) RS / <0.05 (12m) RSE / <0.05 (12m)
Anxiety							
Shahar et al. (2017)	EFT with two chair and empty chair dialogues Location: Israel Duration: 28 weeks (60 min per week)	<i>n</i> = 12 (Females = 5; Males = 7) Clients meeting criteria for social anxiety disorder Age: <i>M</i> = 26.75 Ethnicity: not specified	QED	LSAS / 0.003 SPIN / <0.001 BFNE / 0.003 FSCRS-IS / 0.003 FSCRS-HS / 0.009 FSCRS-SR / 0.09	—	—	LSAS / <0.001 (6m) SPIN / <0.001 (6m) BFNE / <0.001 (6m) FSCRS-IS / <0.001 (6m) FSCRS-HS / 0.054 (6m) FSCRS-SR / <0.001 (6m)
Lingering feelings							

Greenberg et al. (2008)	EFT with two chair and empty chair dialogues Location: Canada Duration: 12 weeks (60 min per week)	<i>n</i> = 46 (Females = 26; Males = 20) Clients with unresolved feelings towards a significant other Age: <i>M</i> = 44.5 Ethnicity: Caucasian (92%); South Asian (4%); and East Asian (4%)	RCT	BDI / 0.47 SCL / 0.62 UFB / 2.28 EFI / 1	Psycho-educational group	BDI / -0.22 SCL / 0.62 UFB / 1.32 EFI / 0.29	BDI / nr (3m) SCL / nr (3m) UFB / nr (3m) EFI / nr (3m)
Paivio and Greenberg (1995)	Empty chair dialogue intervention Location: Canada Duration (ECH): 12 weeks (50 min per week); (PED): 12 weeks (120 min per month)	<i>n</i> = 34 (Females = 22; Males = 12) Clients with unresolved feelings related to a significant other Age: <i>M</i> = 41 Ethnicity: not specified	RCT	SCL / 1.4 IIP / 1.69 UFB / 2.98 SASB / 0.59	Psycho-educational group	SCL / 1.26 IIP / 1.4 UFB / 2.04 SASB / 0.46	SCL / <0.001 (4m) IIP / <0.001 (4m) UFB / <0.001 (4m) SASB / <0.001 (4m)
Other problems							
Shahar et al. (2012)	Two chair dialogue Location: USA Duration: 5-8 weeks (60 min per week)	<i>n</i> = 10 Clients who are self-critical Age: <i>M</i> = 46.4 Ethnicity: not specified	QED	BDI / <0.05 BAI / <0.05 FSCRS-IS / <0.05 FSCRS-HS / <0.05 FSCRS-SR / ns SCS / ns	—	—	BDI / <0.05 (6m) BAI / <0.05 (6m) FSCRS-IS / <0.05 (6m) FSCRS-HS / ns (6m) FSCRS-SR / <0.05 (6m) SCS / <0.01 (6m)
Stiegler et al. (2017)	Two chair dialogue Location: Norway Duration: 10, 12 or 14 weeks (60 min per session)	<i>n</i> = 21 (Females = 15; Males = 6) Clients who are self-critical Age: <i>M</i> = 38.2 Ethnicity = 100% Caucasian	QED	<0.001 BAI / <0.003 FSCRS / <0.002	BDI / Empathic attunement	BDI / 0.03 BAI / 0.06 FSCRS / ns	—

Trachsel et al. (2012)	Two chair intervention Location: Switzerland Duration: 2 weeks (60 min per week)	n = 50 (Females = 29; Males = 21) Clients with partnership ambivalence: Age: M = 38.3 Ethnicity: not specified	RCT	CES-D / 0.25 PSQ / 0.14 SWLS / 0.24 ARCOS / 0.83	Decision cube technique	CES-D / 0.14 PSQ / 0.06 SWLS / 0.27 ARCOS / -0.48	CES-D / ns (4m) PSQ / nr (4m) SWLS / nr (4m) ARCOS / <0.001 (4m)
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Interventions.

Emotion-focused chairwork techniques. Watson, Gordon, Stermac, Kalogerakos and Steckley (2003), Greenberg and Watson (1998) and Goldman et al. (2006) investigated the effect of EFT interventions on improving depressive symptoms in adults with major depressive disorder. The EFT interventions in each of these studies used client-centred relational elements for the first three sessions and experiential interventions thereafter including: two-chair dialogues for self-evaluative splits; empty-chair dialogues for lingering feelings; systematic evocative unfolding; and more generally, experiential responding and focusing. There was a general expectation that therapists would implement a minimum of one intervention every two to three sessions (after session three).

Robinson, McCague and Whissell (2014) investigated the effects of a group-based emotion-focused intervention on improving symptoms of anxiety and depression in anxious and depressed adults. This intervention consisted of: psychoeducation; single participant chairwork with other participants observing; and post-intervention reflections on the participant's chairwork.

Shahar et al. (2017) investigated the effect of an EFT intervention on improving symptoms of social anxiety in adults with social anxiety disorder. The EFT intervention used a combination of client-centred relational elements and the following marker-guided experiential interventions: two-chair dialogues for self-evaluative splits, empty-chair dialogues for lingering feelings and focusing.

Three studies implemented stand alone, emotion-focused chair-based interventions. Shahar et al. (2012) and Stiegler et al. (2017) investigated the effects of the two-chair dialogue intervention for self-evaluative splits on improving

psychological distress in self-critical adults. In the latter study, the two-chair dialogue intervention was added for five sessions after a baseline treatment focused on alliance building, empathic attunement and therapeutic presence and genuineness. Outcomes after the two phases are compared. Trachsel, Ferrari and Holtforth (2012) investigated the effects of the two-chair approach on partnership ambivalence. Over the course of two weeks, two intervention sessions were conducted. The first session served as exploration and preparation for the specific interventions in the second session. A structured intervention manual of the two-chair approach were used (Trachsel, 2009).

Two studies investigated the effects of EFT on improving psychological distress in adult survivors of childhood abuse. Paivio and Nieuwenhuis (2001) used a specialised treatment manual (Emotion-Focused Therapy for Adult Survivors [EFT-AS]; Paivio, 1996) with three interrelated therapeutic tasks: empathic responding; gestalt-derived imagery techniques; and empty-chair dialogues with the perpetrator(s) of abuse. The empty-chair dialogues were generally introduced in the fourth session and used throughout therapy according to individual client processes and needs. Paivio et al. (2010) compared two versions of a specialised treatment manual (Emotion-Focused Therapy for Trauma [EFTT]; Paivio & Pascual-Leone, 2010) incorporating either imaginal confrontation (IC) or empathic exploration (EE). The protocols were identical except the IC condition used empty-chair dialogues with the perpetrators of abuse. The empty-chair dialogues were introduced in the fourth session and used throughout therapy according to individual client processes and needs. In the EE condition issues were explored exclusively in interaction with the therapist, using empathic responding.

Two studies investigated the effects of EFT on improving psychological distress in adults with lingering feelings towards a significant other. Greenberg et al. (2008) used a specialised EFT treatment manual (Greenberg, Malcolm & Warwar, 2002) that focused on facilitating the resolution of emotional interpersonal injuries. The treatment protocol incorporated four phases that overlapped: empathic responding; empty-chair dialogues (no later than the third session and if suitable, in at least half the sessions in this phase); two-chair work for self-interruptive splits; and promoting the entitlement of unmet needs. Paivio and Greenberg (1995) used the EFT manual described by Greenberg et al. (1993). The general style was client-centred, involving empathic responding plus active process-directive intervention. At in-session markers of unfinished business, the therapist guided clients through an imaginary dialogue with their significant other, encouraging them to express their unresolved feelings.

Comparison interventions. Seven studies employed comparison interventions including cognitive behavioural therapy (CBT; Watson et al., 2003); Client-centred therapy (CCT; Goldman et al., 2006; Greenberg & Watson, 1998); Decision Cube Technique (DCT; Trachsel et al., 2012); psychoeducational groups (Greenberg et al., 2008; Paivio & Greenberg, 1995); and empathic exploration (Paivio et al., 2010). The following section provides further details regarding these interventions.

Cognitive Behavioural Therapy (CBT). Watson et al. (2003) compared EFT to CBT in the treatment of adults with major depressive disorder. The CBT protocol was conducted according to the cognitive therapy treatment for depression outlined by Beck, Rush, Shaw and Emery (1979). The treatment was primarily a cognitive therapy with some behavioural components, such as the recording of daily activities and behavioural experiments.

Client-centred therapy (CCT). Both Greenberg and Watson (1998) and Goldman et al. (2006) compared EFT to CCT in the treatment of adults with major depressive disorder. The treatment followed the manual for relational CCT (Greenberg & Goldman, 1999). Therapists in this condition adopted the three fundamental relational attitudes of empathy, positive regard, and congruence. The goal is to provide a genuinely empathic, validating environment to promote self-exploration and the strengthening of the self.

Decision Cube Technique (DCT). Trachsel et al. (2012) compared an EFT intervention to DCT in the treatment of clients with partnership ambivalence. In the DCT condition, clients wrote down the advantages and disadvantages of both sides of their ambivalence within a graphically depicted decision-cube that contains four blank spaces (Bents, 2006).

Psychoeducational group. Paivio and Greenberg (1995) and Greenberg et al. (2008) compared EFT to psychoeducational groups in the treatment of clients with unresolved feelings towards a significant other. In the former study, the psychoeducational content was both manualised (Paivio, 1992) and paralleled the information component of the EFT condition, and was derived from Greenberg et al.'s (1993) conceptualisation of unfinished business. In the latter study, the psychoeducation group manual was devised specifically for the study and covered topics such as: understanding unfinished business and how it disrupts adaptive functioning; the role of pain in experiencing and recovering from interpersonal emotional injuries; how to resolve an injury.

Format. The majority of the chairwork and comparator interventions were implemented individually. One study presented the EFT intervention sessions in a

group setting (Robinson et al., 2014), incorporating a combination of the following presentation formats: lectures, group discussions and experiential activities (e.g. single participant chairwork session with other participants observing).

Setting. All of the intervention activities reported were conducted at clinics within the research facility where the studies were taking place.

Therapists and adherence. Trained professionals delivered most of the intervention content, including qualified, doctoral and master's level clinical psychologists. The majority of interventions reported specific training in EFT. This ranged from four hours (Trachsel et al., 2012) to 100 hours (Robinson et al., 2014) but most of the studies reported between 20 and 54 hours (Greenberg et al., 2008; Paivio & Greenberg, 1995; Paivio et al., 2010; Paivio & Nieuwenhuis, 2001; Stiegler et al., 2017; Watson et al., 2003). Shahar, et al. (2012) reported four months of training, Greenberg and Watson (1998) reported six months of training and Shahar et al. (2017) reported 'extensive training'. These studies did not specify the total number of hours. One study did not report specific EFT training (Goldman et al., 2006).

Five studies reported individual weekly supervision with a trained EFT therapist (Goldman et al., 2006; Greenberg et al., 2008; Greenberg & Watson, 1998; Shahar, et al., 2012; Shahar et al., 2017). Two studies reported weekly group supervision (Paivio & Greenberg, 1995; Watson et al., 2003), and one study reported weekly individual and group supervision (Paivio et al., 2010). Four studies did not specify supervision implementation (Paivio & Nieuwenhuis, 2001; Robinson et al., 2014; Stiegler et al., 2017; Trachsel et al., 2012).

Investigators were generally diligent about administering process measurements, video-taping sessions and conducting direct observations to encourage treatment fidelity. Eight out of the 12 studies used formal measures of EFT intervention adherence. Two more studies reviewed video-tapes to ensure fidelity. Two studies did not directly assess adherence (Robinson et al., 2014; Trachsel et al., 2012).

Intervention duration. All of the intervention sessions were implemented once per week. Most of the weekly interventions lasted 15 to 20 weeks (Goldman et al., 2006; Greenberg & Watson, 1998; Paivio et al., 2010; Paivio & Nieuwenhuis, 2001; Watson et al., 2003) but ranged from two (Trachsel et al., 2012) to 28 weeks (Shahar et al., 2017). Five studies lasted between five and 14 sessions (Greenberg et al., 2008; Paivio & Greenberg, 1995; Robinson et al., 2014; Shahar, et al., 2012; Stiegler et al., 2017) The mean number of sessions delivered across interventions was 14.

Outcomes. This review examined emotion-focused chair-based interventions that specifically targeted improvements in psychological distress in adults. Psychological distress was operationalised to include a reduction in pathologic measures of psychological illness (e.g. depression, anxiety) and/or an increase in psychological well-being (e.g. life satisfaction, self-compassion, and personal growth). All measurement instruments were standardised, reliable, and well-known self-report questionnaires (See Table 2).

Table 2: Measurement instruments used to assess mental health

Mental health	Instrument (Abbreviation)	Study
Psychological illness		
Depression	Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996; Beck, Steer & Garbin, 1987)	Watson et al. (2003), Goldman et al. (2006), Greenberg and Watson (1998), Greenberg et al. (2008), Paivio et al. (2010), Robinson et al. (2014), Shahar et al. (2012); Shahar et al. (2017); Stiegler et al., (2017)
	Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977)	Trachsel et al. (2012)
Anxiety	Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988)	Robinson et al. (2014), Shahar et al. (2012); Stiegler et al. (2017)
	State-Trait Anxiety Inventory (STAXI) (Spielberger, Gorsuch, & Lushene, 1970)	Paivio et al. (2010)
	Liebowitz Social Anxiety Scale (LSAS) (Liebowitz, 1987)	Shahar et al. (2017)
	Social Phobia Inventory (SPIN) (Connor, et al., 2000)	Shahar et al. (2017)
	Brief Fear of Negative Evaluation Scale (BFNE) (Leary, 1983)	Shahar et al. (2017)
Emotion regulation	Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roener, 2004)	Robinson et al. (2014)
Stress and distress		
Psychological distress	Symptom Checklist (SCL) (Derogatis, 1983; Derogatis, Rickels & Roch, 1976)	Goldman et al., (2006), Greenberg et al. (1998), Paivio et al. (1995), Paivio et al. (2001), Watson et al. (2003)
Subjective stress	Impact of Events Scale (IES) (Horowitz, 1986)	Paivio et al. (2001), Paivio et al. (2010)
	Perceived Stress Questionnaire (PSQ) (Levenstein et al., 1993)	Trachsel et al. (2012)
Interpersonal distress	Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988)	Goldman et al. (2006), Greenberg and Watson (1998), Greenberg et al. (2008), Paivio et al. (1995), Paivio et al. (2001), Paivio et al. (2010), Watson et al. (2003)
	Resolution Scale (RS) (Singh, 1994)	Paivio et al. (2001), Paivio et al. (2010)
	Structural Analysis of Social Behavior Questionnaire (SASB) (Benjamin, 1988)	Paivio et al. (1995), Paivio et al. (2001)
	Unfinished Business Scale (UFB) (Singh, 1994)	Greenberg et al. (2008), Paivio et al. (1995)
Psychological well-being		
Self-compassion	Self-Compassion Scale (SCS) (Neff, 2003)	Shahar et al. (2012)

Self-esteem	Rosenberg Self-Esteem Inventory (RSE) (Rosenberg, 1989)	Goldman et al. (2006), Greenberg and Watson (1998), Paivio et al. (2010), Watson et al. (2003)
Self-criticism	Forms of Self-Criticizing and Self-Reassuring Scale (FSCRS) (Gilbert, Clarke, Hempel, Miles, & Irons, 2004)	Shahar et al. (2012), Shahar et al. (2017); Stiegler et al. (2017)
Forgiveness	Enright Forgiveness Inventory (Enright, Rique & Coyle, 2000)	Greenberg et al. (2008)
Ambivalence	Ambivalence Regarding Continuation Or Separation of the Relationship (ARCOS) (Trachsel & Boller, 2008)	Trachsel et al. (2012)
Life Satisfaction	Satisfaction With Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985)	Trachsel et al. (2012)

Study Designs

Randomized controlled trials (RCTs). Seven of the 12 reviewed studies used random assignment to place participants into a variety of treatment groups and active control conditions. Goldman et al. (2006) and Greenberg and Watson (1998) compared the effects of EFT and CCT. Paivio and Greenberg (1995) and Greenberg et al. (2008) examined differences between EFT and a psychoeducational group. Trachsel et al. (2012) compared a two-chair intervention to the decision cube technique. Watson et al., (2003) compared differences between EFT and CBT and Paivio et al. (2010) compared two versions of Emotion-Focused Trauma Therapy.

Quasi-experimental designs (QEDs). Five of the 12 reviewed studies used a quasi-experimental design with pre and post within-subject evaluations of the targeted interventions without any control or comparison group. Four of these studies assessed outcomes comparing baseline and post-intervention results (Robinson et al., 2014; Shahrar, et al., 2012). Shahrar et al., (2017) used a non-concurrent multiple baseline design.

One study (Paivio & Nieuwenhuis, 2001) used a quasi-experimental design with pre and post between-subject evaluation of Emotion-Focused Therapy and a wait-list control group and one study (Stiegler et al., 2017) implemented a multiple baseline design to examine the effects of adding a two-chair dialogue intervention to empathic attunement.

Follow-up assessment. Nine of the 12 studies measured outcomes at follow-up as well as post-intervention. One study measured follow-up at three months (Greenberg et al., 2008), two studies at four months (Paivio & Greenberg, 1995; Trachsel et al., 2012), one study at six months (Greenberg & Watson, 1998), one

study at nine months (Paivio & Nieuwenhuis, 2001), two studies at 12 months (Paivio & Pascual-Leone, 2010; Robinson et al., 2014), one study at two, four and six months (Shahar, et al., 2012) and one study at both six and 12 months (Shahar et al., 2017). Three studies used only an immediate post-assessment (Goldman et al., 2006; Stiegler et al., 2017; Watson et al., 2003).

Risk of Bias within Studies

The quality assessment of individual studies is detailed in Table 3. Below is a narrative summary of the findings.

Selection bias. Nine out of the 12 studies are not likely to have samples representative of the target population because participants self-referred to the studies (Goldman et al., 2006; Greenberg & Watson, 1998; Paivio & Nieuwenhuis, 2001; Paivio et al., 2010; Shahar et al., 2012; Shahar et al., 2017; Watson et al., 2003; Paivio & Greenberg, 1995; Greenberg et al., 2008). Where applicable, the percentage of subjects that agreed to participate in the study was between 60 and 100 per cent before they were assigned to intervention or control groups. For one study (Stiegler et al., 2017), there was less than 60% agreement.

Study design. Eight out of the 12 studies described their study as randomised (Goldman et al., 2006; Greenberg & Watson, 1998; Paivio et al., 2010; Shahar et al., 2017; Watson et al., 2003; Greenberg et al., 2008; Paivio & Greenberg, 1995; Trachsel et al., 2012). Of these, five studies described their allocation method and used an appropriate randomisation sequence (Paivio et al., 2010; Shahar et al., 2017; Trachsel et al., 2012; Paivio & Greenberg, 1995; Watson et al., 2003). Three studies did not describe the allocation method (Goldman et al., 2006; Greenberg et al., 2008; Greenberg & Watson, 1998).

Confounders. Seven studies reported on confounders and found no important differences between groups prior to the intervention (Greenberg et al., 1998; Greenberg et al., 2008; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Paivio et al., 2010; Trachsel et al., 2012; Watson et al., 2003). Two studies (where it would have benefitted the study design / analytic method) did not report on confounders (Goldman et al., 2006; Shahar et al., 2017).

Blinding. Of the eight studies that had more than one intervention group (Goldman et al., 2006; Greenberg & Watson, 1998; Greenberg et al., 2008; Paivio & Greenberg, 1995; Paivio et al., 2010; Paivio and Nieuwenhuis., 2001; Trachsel et al., 2012; Watson et al., 2003;) none of them reported on whether the outcome assessors were aware of the intervention status of participants and only one reported on whether participants were aware of the research question (Trachsel et al., 2012).

Data collection methods. All of the studies included in the review used data collection tools that were valid and reliable.

Withdrawals and drop-outs. All of the studies described the numbers and/or reasons for withdrawals and drop-outs. Two of the studies reported < 80% completion rate (Robinson et al., 2014; Watson et al., 2003), while the rest reported 80 - 100% completion rate.

Table 3: Risk of bias within studies.

Study	Selection bias	Study design	Confounders	Blinding	Data collection	Withdrawals	Global rating
Goldman et al. (2006)	Weak	Strong	Weak	Moderate	Strong	Strong	WEAK
Greenberg and Watson (1998)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Greenberg et al., (2008)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Paivio and Greenberg (1995)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Paivio and Nieuwenhuis (2001)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Paivio et al. (2010)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Robinson et al. (2014)	Moderate	Moderate	Weak	Moderate	Strong	Moderate	MODERATE
Shahar et al. (2012)	Weak	Moderate	Weak	Moderate	Strong	Strong	WEAK
Shahar et al. (2017)	Weak	Weak	Weak	Moderate	Strong	Strong	WEAK
Steigler et al. (2017)	Weak	Weak	Weak	Moderate	Strong	Strong	WEAK
Trachsel et al., (2012)	Weak	Strong	Strong	Moderate	Strong	Strong	MODERATE
Watson et al. (2003)	Weak	Strong	Strong	Moderate	Strong	Moderate	MODERATE

Results of Individual Studies

Three studies examined outcomes for individuals suffering from depression (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). One study examined outcomes for individuals suffering from anxiety (Shahar et al., 2017). One study examined outcomes for individuals with symptoms of both depression and anxiety (Robinson et al., 2014). Two studies examined outcomes for individuals with unresolved feelings towards a significant other (Greenberg et al., 2008; Paivio & Greenberg, 1995). One study examined outcomes for individuals with partnership ambivalence (Trachsel et al., 2012) and two studies examined outcomes for adult survivors of childhood abuse (Paivio & Nieuwenhuis, 2001; Paivio et al., 2010) and two studies examined outcomes for individuals with high levels of self-criticism (Shahar et al., 2012; Stiegler et al., 2017).

Table 1 depicts either reported or calculated effect sizes from the RCTs and results of significance testing for QEDs within this review. Results are presented according to the primary inclusion criteria of participants as specified by the studies.

Clinical heterogeneity (i.e. clients with differing presentations), methodological heterogeneity (i.e. the studies were not conducted in a similar fashion – estimates from RCTs should not typically be combined with estimates from QEDs) and measure heterogeneity prevented valid mathematical combination. Therefore, I focused on describing the studies, their results, their applicability, and their limitations and on qualitative synthesis rather than meta-analysis.

Results by Client Group

Studies with depressed clients.

Results: RCTs. The results of these studies demonstrated the efficacy of EFT in treating major depression. The effect sizes from pre- to post-therapy were: $d = 2.99$ (Goldman et al., 2006), $d = 2.82$ (Greenberg & Watson, 1998), $d = 1.75$ (Watson et al., 2003).

The difference in effect size between EFT and CCT at the end of therapy in terms of their depression were in favour of EFT, $d = 0.76$ (Goldman et al., 2006); $d = 0.22$ (Greenberg & Watson, 1998). The same was true for general symptom distress, $d = 1.24$ (Goldman et al., 2006); $d = 0.56$ (Greenberg & Watson, 1998). In addition, the effect sizes for differences between groups at post-treatment for self-esteem were also in favour of EFT, $d = 0.4$ (Goldman et al., 2006); $d = 0.66$ (Greenberg & Watson, 1998) as were interpersonal problems, $d = 0.42$ (Goldman et al., 2006); $d = 1.15$ (Greenberg & Watson, 1998).

The effect sizes between EFT and CBT at the end of therapy in terms of their depression and their general symptom distress were negligible, $d = 0.14$ and $d = 0.05$, respectively (Watson et al., 2003). However, the effect sizes for differences between groups at post-treatment for self-esteem and interpersonal problems were larger, $d = 0.21$ and $d = 0.44$, respectively, in favour of EFT.

At six-month follow-up (Greenberg & Watson, 1998), the authors report that treatment gains for EFT were maintained, but there were no significant differences compared to the comparison intervention (CCT).

Results: QEDs. Results from Robinson et al. (2014) showed no statistical differences for depressive symptoms or anxiety symptoms pre- to post-treatment.

However, post-group scores for emotional regulation were significantly improved compared with pre-group scores ($p = 0.06$). Whilst the authors did not report significance at follow-up, they did report clinical differences at each time point. Specifically, pre-BDI scores fell in the severe clinical range, while post-group scores fell in the moderate clinical range. This was maintained at follow-up. Pre- and post-group BAI scores fell in the moderate clinical range, while follow-up scores improved over time and fell in the mild range. Pre- and post-group DERS scores exceeded the average range for clinical populations but at follow-up only fell slightly above the average range for nonclinical samples.

Studies with anxious clients.

Results: QEDs. Results from Shahar et al. (2017) demonstrate the efficacy of EFT in treating social anxiety. Post-intervention scores were significantly lower than pre-group scores on the SPIN ($p = <0.001$), the LSAS ($p = 0.003$) and the BFNE ($p = 0.003$). Post-intervention scores were also significantly lower than pre-group scores on three subscales of self-criticism ([‘Inadequate-Self’] $p = 0.003$, [‘Hated-Self’] $p = 0.009$, [‘Reassuring-Self’] $p = 0.09$). Pre-follow up scores suggest that effects were maintained at six month follow-up across all outcome measures.

Studies with self-critical clients.

Results: QEDs. Results from Shahar et al. (2012) demonstrate that an emotion-focused two-chair dialogue intervention is associated with a significant decrease in two sub-scales of self-criticism ([‘Inadequate-Self’] $p < 0.05$, [‘Hated-Self’] $p < 0.05$). Depression ($p < 0.05$) and anxiety ($p < 0.05$) also decreased significantly post-intervention. There were no post-intervention improvements on one sub-scale of self-criticism (‘Reassuring-Self’) or self-compassion. However, there were pre-follow up

improvements on both these measures and moreover, effects were maintained for all outcome measures.

Results from Stiegler et al. (2017) demonstrated that an emotion-focused two-chair dialogue intervention is associated with a significant decrease in symptoms of self-criticism ($p < 0.002$), depression ($p < 0.001$) and anxiety ($p < 0.003$). When compared to a treatment phase consisting of empathic attunement to the clients' emotional processes, self-criticism did not decrease significantly more after the introduction of the two-chair dialogue but symptoms of depression and anxiety did ($p = 0.03$ and $p = 0.06$, respectively).

Studies with adult survivors of childhood abuse.

Results: RCTs. Results from Paivio et al. (2010) demonstrated the efficacy of EFTT-IC in treating trauma symptoms in adult survivors of childhood abuse. The effect sizes from pre- to post-therapy fell in the huge range, as defined by Cohen (1988) ($d = 1.56$). The effect sizes for differences between groups at post-treatment were in favour of IC over EE for depression ($d = 0.61$), anxiety ($d = 0.44$) and self-esteem ([RSE] $d = 0.45$; [RS] $d = 0.91$ and [IIP] $d = 1.12$). However, the effect sizes between the two groups at the end of therapy in terms of their trauma symptoms was 0.32, in favour of EE. Treatment effects were maintained at 12-month follow-up.

Results: QEDs. Results from Paivio and Nieuwenhuis (2001) demonstrated the efficacy of EFT-AS in treating trauma symptoms ($p < 0.01$), psychological distress ($p < 0.01$) and interpersonal distress ([RS] $p < 0.001$, [IIP] $p < 0.01$, [SASB-A] $p < 0.001$). There were no significant difference on interpersonal distress when measured by the SASB-C. EFT-AS showed significantly greater improvements than wait-list

controls across all measures apart from the SASB-C and treatment effects were maintained at six month follow-up.

Studies with clients with lingering feelings.

Results: RCTs. The results of these studies demonstrated the efficacy of EFT in improving psychological distress in clients with lingering feelings towards a significant other. The effect sizes from pre- to post-therapy were: $d = 0.47$ for depression (Greenberg et al., 2008), $d = 0.62$ for psychological distress (Greenberg et al., 2008); $d = 1.4$ (Paivio & Greenberg, 1995), $d = 2.28$ for interpersonal distress (Greenberg et al., 2008); $d = 1.69$ [IIP], $d = 2.98$ [UFB], $d = 0.59$ [SASB] (Paivio & Greenberg, 1995); $d = 1$ for forgiveness (Greenberg et al., 2008).

The difference in effect size between EFT and the psychoeducational group at the end of therapy were in favour of EFT for psychological distress, $d = 0.62$ (Greenberg et al., 2008); $d = 1.26$ (Paivio & Greenberg, 1995), interpersonal distress, $d = 1.32$ (Greenberg et al., 2008); $d = 1.4$ [IIP], $d = 2.04$ [UFB], $d = 0.46$ [SASB] (Paivio & Greenberg, 1995) and forgiveness, $d = 0.29$ (Greenberg et al., 2008). However, effect sizes between groups at post-treatment were in favour of the psychoeducational group for depression ($d = 0.22$). Treatment effects from Paivio and Greenberg (1995) were maintained at follow-up. Follow-up effects from Greenberg et al. (2008) were not reported or discussed.

Studies with clients with partnership ambivalence.

Results: RCTs. Results from Trachsel et al. (2012) showed that a two-chair intervention was effective in improving psychological distress in clients with partnership ambivalence. The effect sizes pre-post therapy were $d = 0.25$ for depression, $d = 0.14$ for subjective stress, $d = 0.24$ for life satisfaction and $d = 0.83$ for

ambivalence. The difference in effect size between the two-chair intervention and the decision cube technique were in favour of the TCA for depression ($d = 0.14$), subjective stress ($d = 0.06$) and life satisfaction ($d = 0.27$) but in favour of the DCT for ambivalence ($d = 0.48$). The authors only reported pre-follow-up significance levels for depression, which were non-significant for both groups, and levels of ambivalence, which were significantly reduced for both groups.

Discussion

The aim of this review was to synthesise the research on the implementation of emotion-focused chair-based interventions in order to establish their effectiveness in reducing symptoms of psychological distress in adults. Twelve studies that included an emotion-focused chair-based intervention and which measured outcomes quantitatively were identified. Seven studies used a randomised controlled design comparing the active intervention with another therapeutic approach.

Summary of Evidence

Although a small number of studies in total, several interventions were found to improve psychological distress post-intervention for clients with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse. Moreover, where reported, these changes appear to be sustainable over time.

Four studies examined treatment effects for depressed clients (Goldman et al., 2006; Greenberg & Watson; Robinson et al., 2014; Watson et al., 2003). Two of those studies (Goldman et al., 2006; Greenberg & Watson, 1998) compared EFT with CCT and found, in terms of depression symptom scores, effect sizes in favour of EFT over CCT at the end of therapy. Since EFT combines person-centred principles with

chairwork techniques and CCT is person-centred therapy alone, this outcome provides fairly good evidence for the efficacy of chairwork as an active and potentially effective component of EFT for depression. The effectiveness of chairwork is a little harder to determine when EFT was compared against CBT (e.g. Watson et al., 2003), as outcomes could be linked to interventions other than emotion-focused chairwork. Results from this study showed EFT to be an effective intervention for people with depression but results were comparative, in terms of depression symptom reduction, for EFT and CBT. Finally, group EFT with chairwork (Robinson et al., 2014) showed no statistical improvements post-treatment for depression symptom scores, which could indicate that the format of delivery (i.e. individual or group therapy) has an impact on therapeutic outcome.

One study examined treatment effects for socially-anxious clients (Shahar et al., 2017) and found EFT with two-chair and empty-chair dialogues to be an effective intervention for improving symptoms in this client group. In this case, though chairwork techniques featured heavily in the intervention, solid conclusions regarding the efficacy of chairwork techniques as the active ingredient cannot be made because the study did not employ a control or comparison group.

Two studies examined treatment effects for self-critical clients (Shahar et al., 2012; Stiegler et al., 2017) and found that two-chair dialogues were effective in improving symptoms post-intervention for these clients. Since these studies employed brief interventions grounded solely in emotion-focused chairwork, the results from these studies demonstrate the potential efficacy of chairwork. The same is true for one study that examined symptom improvement for clients with partnership ambivalence

and found a stand-alone two-chair intervention to be effective in improving psychological distress (Trachsel et al., 2012).

Two studies examined treatment effects for adult survivors of childhood abuse (Paivio et al., 2010; Paivio & Nieuwenhuis, 2001). Both studies demonstrated the effectiveness of EFT in treating trauma symptoms. EFT with chairwork was favoured over EFT with empathic exploration (Paivio et al., 2010), which provides good evidence for the efficacy of chairwork. The specific effects of chairwork are harder to deduce when EFT was compared against wait-list controls (Paivio & Nieuwenhuis, 2001). Two studies examined treatment effects for clients with lingering feelings and both studies favoured EFT with empty chair and two-chair dialogues over psycho-educational groups for improving symptoms of psychological distress. Again, however, it is difficult to deduce the effectiveness of chair-based techniques as outcomes in these studies could relate to elements of EFT other than chairwork (e.g. the therapeutic relationship).

Limitations at Study and Outcome Level

There are a number of important limitations in this area of research that need addressing for this field to move forward. Firstly, almost half of the studies in the review employed quasi-experimental designs. Therefore, they can only provide limited conclusions about treatment effects because they lack control for alternative explanations. RCTs, on the other hand, are considered the gold standard for testing intervention efficacy (Shadish, Cook, & Campbell, 2002) and it was encouraging that seven of the included studies employed this design. However, four of the RCTs did not report effect sizes and they needed to be calculated from the available information. Future research investigating chairwork interventions should routinely

report effect sizes for all outcomes. Also, the method of recording data in these studies (displayed as changes measured before and after the intervention and before and after follow-up) is limited as there can be a tendency for assessment measures to regress to the mean, or for there to be changes in symptom level over the natural course of the illness (Da Paz & Wallander, 2017).

A further limitation is that while all of the studies used collection tools that were valid and reliable, they also all relied solely on self-report instruments to assess outcome. Future investigations which add objective measurements, such as observational measures, clinical interview or reports from other sources (e.g. a loved one) would strengthen and support the reporting of definitive conclusions.

Many studies reported low sample size as a major limitation to generalisability. Moreover, in the majority of cases, samples were not likely to be representative of the target population because participants self-referred (and therefore, possibly made up of particularly compliant individuals). Furthermore, it is difficult to generalise the findings from the studies to a more diverse sample as those who responded were typically English-speaking Caucasian females, aged 26 to 46. Therefore, conclusions should be made with caution when considering the treatment effect of chairwork interventions in the context of a multi-cultural, multi-generational and gender inclusive population.

In addition, the studies in this review employed a variety of emotion-focused chairwork interventions (two-chair dialogues for self-evaluative splits; two-chair dialogues for self-interruptive splits; empty-chair dialogues for lingering feelings; and empty-chair dialogues with the perpetrator[s] of abuse) for a variety of problems (depression, anxiety, self-criticism, abuse, ambivalence). Moreover, it was not always

clear what or how much of the intervention was being used. Therefore, it is difficult to merge the findings and identify precisely what is differentially effective.

Finally, most of the studies administered process measurements and video-taped sessions to encourage treatment fidelity. However, it would be useful to provide evidence that the process hypothesised to be affected by the intervention actually changed and can be linked to mental health. Unfortunately, it was beyond the scope of this review to examine mechanisms of change.

Limitations at Review Level

There are also several limitations of the way in which this review has been conducted that may have introduced bias into the results and limit the strength of the conclusions that can be drawn. First, the results are based solely on published studies so there may be a publication bias. Second, the eligibility assessment, data extraction and quality assessment of the studies was conducted independently by one researcher so there may be a researcher bias. Third, only studies that were written in English were included in the review which may have excluded potentially important studies. Fourth, the robustness of the findings is severely limited by the number and size of the studies in this relatively novel field of research. Finally, the variety of psychological problems examined and heterogeneity in outcome and design meant that a meta-analysis was not possible.

Clinical Implications

Overall these findings provide tentative evidence that emotion-focused chairwork techniques might alleviate psychological distress in individuals with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse. However, future trials are

needed to help clinicians determine whether chairwork specifically is clinically effective. For example, the application of the emotion-focused interventions in this review varied and moreover, were not always clearly defined. Therefore, more work is needed to: address the extent to which the chairwork techniques are responsible for improvement in outcomes; establish who responds best to these interventions and; determine whether and how chairwork is effective for disorders other than those included in this review.

Conclusions

Emotion-focused chairwork techniques show promise for reducing psychological distress in individuals with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse. There is sufficient evidence to support further investigation with, adequately powered, RCTs to answer some of the questions raised in this review. Ideally, such trials would have homogenous and clear outcome measures for EFT and include unified comparison conditions and comparisons with the established evidence base (e.g. CBT in depression), so as to provide an evidence base for this type of intervention to be included in services.

Empirical Study

Abstract

Anorexia nervosa (AN) is a difficult disorder to treat and there is a lack of clear evidence for effective therapies. Accordingly, there is a demand to develop new approaches for the treatment of adults with AN. Qualitative research has identified the experience of an ‘anorexic voice’ (AV) in individuals with AN, which has been hypothesised to contribute to the development and maintenance of the illness. Emotion-focused therapy (EFT) has been considered for the treatment of eating disorders (EDs) as this approach involves processing emotional experience in order to deal with difficulties in affect regulation, thus rendering AN as unnecessary in coping with negative emotions. It also offers techniques (e.g. the two-chair dialogue for self-evaluative splits) for dealing explicitly with the AV. Therefore, this study aimed to investigate the feasibility, acceptability and efficacy of a brief EFT intervention that focuses on the AV (EFT-AV) for adult outpatients with AN. Six adults with AN were recruited from an outpatient service into a single-case experimental design. Four participants completed the intervention, consisting of six, weekly one hour sessions. Treatment recruitment, retention and adherence indicated that the intervention was feasible. Thematic analysis of participant follow-up interviews demonstrated that the intervention was considered acceptable by participants. Visual analyses showed that relative to baseline, the extent to which all participants identified with, endorsed and experienced the AV decreased from baseline to intervention. One participant showed an improvement in eating disorder behaviour and cognitions and two participants indicated a less threatening view of the illness over the course of the intervention. Trends were also indicated for increased motivation to change and hope of recovery. Overall this study provides new but tentative evidence highlighting the potential of

EFT-AV as a feasible and acceptable intervention for some adults with AN. The intervention now warrants further, more rigorous evaluation.

Applying emotion-focused therapy to work with the ‘anorexic voice’ within anorexia nervosa: A brief intervention.

Introduction

Anorexia Nervosa (AN) is a serious, potentially life-threatening eating disorder (ED) characterised by self-starvation and excessive weight loss (American Psychiatric Association, 2013). It is a difficult disorder to treat (Steinhausen, 2002) and there is a lack of clear evidence for effective therapies (Bulik, Berkman, Brownley, Sedway & Lohr, 2007). Historically, maintenance models for AN have centralised various intra- and interpersonal factors, such as the preoccupation with shape and weight, pro-anorexia beliefs and responses from close others to the illness (Fairburn, Shafran, & Cooper, 1999; Schmidt & Treasure, 2006). However, in clinical practice, research has shown that a significant number of individuals with AN do not improve following therapies based on these theories. Several studies have shown that they are, at most, only equally effective as comparison treatments (Dare, Eisler, Russell, Treasure, & Dodge, 2001; McIntosh, et al., 2005; Schmidt, et al., 2012; Zipfel, et al., 2014). One of the main challenges in treating individuals with AN is that they are often ambivalent about engaging in treatment (Higbed & Fox, 2010). As a result, guidelines for the treatment of AN are tenuous (National Institute for Health and Clinical Excellence [NICE], 2017). Accordingly, there is a demand to develop new approaches for the treatment of adults with AN which both better engage clients and explain how and why symptoms are maintained (Wilson, Grilo & Vitousek, 2007).

The Self vs. AN

Research into health beliefs suggests that how an individual relates to their ‘illness’ can significantly impact on coping and treatment outcomes (Petrie, Cameron, Ellis, Buick, & Weinman, 2002). A widely established theory of health beliefs within physical health research, the self-regulation model (SRM; Leventhal, Nerenz & Steele, 1984) suggests that people tend to have fairly stable illness beliefs, which help them to cope with and understand their experiences. However, attempts to apply the SRM to mental health have been unsuccessful (Barrowclough, Lobban, Hatton, & Quinn, 2001). According to the literature, clients with mental health difficulties understand their illnesses quite differently than would be predicted by the SRM. For example, Kinderman, Setzu, Lobban and Salmon (2006) demonstrated that people do not necessarily distinguish between the self and the mental illness and moreover, that people’s relationship with their mental health difficulties differed over time.

Studies investigating illness perceptions in AN suggest that people with AN do not have a stable model of their ED (Federici & Kaplan, 2008; Holliday, Wall, Treasure, & Weinman, 2005). Serpell, Treasure, Teasdale and Sullivan (1999) found that people with AN typically do not view the ED as an illness but as an egosyntonic part of their identity, and positive beliefs about the disorder are endorsed. This supposed ‘blurring’ of self and mental illness (Higbed & Fox, 2010) presents a significant barrier to the essential conditions necessary for treatment (i.e. an awareness that one is unwell and therefore in need of treatment) and may help to explain ambivalence about treatment engagement in AN (Higbed & Fox, 2010). Current therapeutic approaches for AN define the ‘illness’ as being separate to the self and explain recovery in terms of no longer having AN. However, research on illness

perceptions in AN suggests that individuals may need to be helped to maintain a life with AN, without it taking control (Higbed & Fox, 2010).

The ‘Anorexic Voice’ (AV)

In a study investigating illness perceptions in AN, Higbed and Fox (2010) found that many participants experienced AN as both separate from themselves and at the same time part of their identity. The authors argue that this dual conceptualisation may help to explain why many individuals with AN struggle to part with their ED. In this qualitative study, participants described their relationship with AN on a scale from AN having total control, to it being an entirely separate and external entity. This distinction led to the conceptualisation of AN as a ‘voice’, which incorporated descriptions of destructive eating behaviour and irrational thought processes. Participants described the voice as powerful and dominant and associated it with the idea of AN attempting to take over the self.

The experience of an ‘anorexic voice’ (AV) in individuals with AN has now been identified in several qualitative studies (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams & Reid, 2012). It is worth noting that these experiences are not necessarily limited to AN. Critical internal voices have also been reported in other ED groups (Pugh, Waller, & Esposito, 2018) and those authors suggest that an ‘eating disorder voice’ (EDV) is more appropriate terminology. However, the majority of the available research focuses on the experience within AN, therefore it will be referred to as an AV in the present study.

Incidence of the AV is estimated at over 90% in people with EDs (Noordenbos, Aliakbari, & Campbell, 2014). The AV is experienced as a second or third person commentary on thoughts and behaviours relating to eating weight and

shape (Tierney & Fox, 2010), setting it apart from ED cognitions. The AV is typically described as both a separate entity and a part of one's own inner speech (Higbed & Fox, 2010), distinguishing it from more typical self-critical cognitions (Noordenbos, Aliakbari, & Campbell, 2014) or 'true' auditory hallucinations (Pugh, 2016).

Individual descriptions of the AV suggest that it changes in nature and intensity over time (Tierney & Fox, 2010). Typically, the AV tends to surface during the onset of the illness and is often described as providing comfort and security at this stage. During this phase, the AV provides the individual with guidance and reassurance and facilitates the numbing of distressing emotions (Dolhanty & Greenberg, 2007; Tierney & Fox, 2011). As the illness progresses however, the AV becomes critical, hostile and controlling, encouraging increasingly disruptive and irrational eating behaviours (Williams & Reid, 2012). A meta-synthesis of qualitative studies exploring outcomes in AN suggests that learning to protect against the AV is a central part of recovery (Duncan, Sebar, & Lee, 2015) and relapse, where individuals might be 'seduced' by the AV and go back to the ED (Fox, Federici, & Power, 2012). Research indicates that clients desire a greater understanding of the AV by professionals (Davies, 2008; Duncan, Sebar, & Lee, 2014) and that interventions which help manage such experiences are both valued and capable of achieving improvements in pathology (Dolhanty & Greenberg, 2009; Mountford & Waller, 2006). In addition, interventions which facilitate direct communication with internal voices have proven effective, empowering and non-harmful in treating depression, anxiety and even psychosis (Corstens, Longden & May, 2011; Greenberg & Watson, 1998).

Despite these findings, working with internal voices, including those arising within the context of EDs, is not without controversies. Wright and Hacking (2012) have argued that externalising AN diminishes client's responsibility over their eating disordered behaviour and also recovery. However, an externalising perspective does not mean that the client loses responsibility for their actions. Externalising conversations need to be handled sensitively so as to ensure that the client does not hear "you can't help it, it's the anorexia" (Eisler, Simic, Blessitt, & Dodge, 2017, p. 33). In the Maudsley Service Manual for Child and Adolescent Eating Disorders (Eisler et al., 2017) they also suggest that clients can feel invalidated and patronised by externalisation of the illness. The authors warn that if used too liberally or without care, AN can become increasingly dramatic and fearful, which, for some clients, cannot be easily separated from their core sense of self. The authors recommend, therefore, that therapists carefully and tentatively explore the extent to which the client can identify with this concept without insisting that AN is definitely and always in control and a totally separate entity. Finally, there are researchers who argue that the AV is a social construct developed by researchers rather than from client experience (Maisel, Epston & Borden, 2004). However, there are reports that individuals identify with the experience of an AV prior to contact with services (Williams, King & Fox, 2015). In summary, not enough is known about the particular impact of externalising as a therapeutic intervention. The risks and controversies of working with internal voices highlight and contextualise the importance of conducting a feasibility study.

Emotion-focused therapy (EFT)

Emotions have been demonstrated to play an important role in the development and maintenance of AN. Individuals with AN experience increased negative, and decreased positive, emotions (Davies, Schmidt, Stahl, & Tchanturia, 2011; Torres, Lencastre, Roma-Torres, Brandao, & Queiros, 2011). They have difficulties describing, labelling, and recognising emotions (Harrison, Sullivan, Tchanturia, & Treasure, 2009; Oldershaw, et al., 2010; Russell, Schmidt, Doherty, Young, & Tchanturia, 2009) and deficits in emotion regulation compared to healthy controls (Haynos & Fruzzetti, 2011; Lavender, et al., 2015; Oldershaw, et al., 2012). Maintenance models of AN hypothesise that engaging in ED behaviours helps to avoid or suppress negative emotions (Cooper, Wells & Todd, 2004; Schmidt & Treasure, 2006; Wildes, Ringham, & Marcus, 2010), which suggests that an individual would only be motivated to change their behaviour when the emotional distress increases.

Emotion-focused therapy (EFT; Greenberg, 2011) is designed to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions and change maladaptive emotions (Greenberg, 2008). It combines person-centred relational principles (empathic responding, genuineness, unconditional positive regard [Rogers, 1961]) with more directive evocative interventions (e.g. chairwork [Perls, Hefferline & Goodman, 1951]), derived from Gestalt and experiential therapies and thought to further enhance emotional processing. EFT has been considered for the treatment of EDs (Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009) as this approach involves processing emotional experience in order to deal with difficulties in affect regulation, thus

rendering AN as unnecessary in coping with negative emotions. It also offers techniques for dealing explicitly with the AV. A recent systematic review explored the efficacy of emotion-focused treatments for AN (Sala, Heard, & Black, 2016). Their findings suggest that emotion-focused treatments may be acceptable, feasible, and effective for adolescents and adults with AN.

Chairwork

Typically, EFT involves three types of chairwork: two-chair dialogues for self-evaluative splits (in which one aspect of the self is critical or coercive towards another aspect), two-chair enactments for self-interruptive processes, (when one part of the self interrupts or constricts emotional experience and expression), and empty-chair dialogues for unresolved feelings towards a significant other (Greenberg, 2008; Greenberg, 2010; Greenberg, 2011).

EFT is designed to encourage a relational approach to internal critical voices. The present study focuses on chairwork for the AV as it is thought that experiential chairwork interventions that are used within EFT could be used to explore the functions of the anorexic voice, encourage assertive responding, set boundaries, and develop more affiliative and compassionate internal dialogues. Given that the AV is experienced in a dialogical fashion, dialogical interventions would seem to have utility. In two-chair work, an individual moves between two chairs, embodying the inner critic in one chair and responding to it in the other. Throughout the intervention, the individual is encouraged to focus on how it feels to be attacked by their inner critic (Stiegler et al., 2017). This process is repeated several times, before the client is invited to express what they need from their critical voice. This usually has one of two outcomes for the client: either they assert themselves against the critic with anger, or

there is an outburst of sadness and appeal for support (Pugh, 2017b). Returning to the critical chair, the inner critic either continues to attack the client (in which case the client is encouraged to stay assertive [Greenberg, 2011]) or the critic ‘softens’ and a more compassionate form of self-to-self relating is generated (Greenberg 1979). It is theorised that two-chair dialogues putting the AV in the chair will either: (1) encourage more assertive responses to the AV and therefore, reduce the severity of self-attacking and facilitate integration and negotiation between the AV and the self, or (2) generate more compassionate self-to-self relating. In this way, working with the AV is assumed to increase emotional awareness and/or help clients to cope with and manage emotions in more adaptive ways.

The Present Study

The overall aim of the present study is to examine whether a brief form of EFT that focuses on the AV (EFT-AV) is feasible and acceptable as an intervention for adults with AN, presenting to outpatient ED services. The study is exploratory and aims to answer the following research questions:

- 1) Is EFT-AV a feasible intervention for adults with AN who present to outpatient ED services?
- 2) Do participant’s evaluations of the intervention indicate that it is considered an acceptable treatment?
- 3) Can EFT-AV lead to improvements in: a) the relationship with the AV; b) illness beliefs; c) ED cognitions and behaviours and d) motivation to change and hope of recovery?

The study employed a single-case experimental design (SCED). Clients diagnosed with AN who are experiencing an AV and who are on a waiting list for psychological

treatment for their ED were recruited from outpatient ED services. The intervention itself involved six, weekly, individual one hour sessions. Feasibility of the intervention was determined by measuring recruitment rate, treatment duration and retention and treatment fidelity. Acceptability of the intervention was determined by a thematic analysis of post-intervention interviews. Participants were asked to complete standardised weekly measures of symptomatology, as well as measures of the relationship with the AV, illness beliefs and pre- and post-intervention measures of motivation to change and hope of recovery. Participants' outcomes were explored at an individual level using visual analyses of graphed data.

Methods

Participants

Participants were recruited from an adult ED outpatient service in the UK. The time period for recruitment was October 2017 – December 2017.

Inclusion criteria. The following inclusion criteria were used for the study:

- 1) First or second episode of AN.
- 2) Reported experience of an AV.
- 3) Sufficient command of English to comprehend instructions and measures without the use of an interpreter.

The following exclusion criteria were used for the study:

- 1) Co-morbid psychosis.
- 2) Current alcohol or substance dependence.
- 3) Concurrent additional psychotherapy.
- 4) History of severe trauma.

Inclusion and exclusion criteria were justified on account of needing to evaluate the intervention with as few confounding variables as possible. Eventually, the inclusion criteria were relaxed to enable the recruitment of participants with a-typical AN and any episode. Recent research indicates a relationship between voice appraisals and eating pathology across diagnoses (Pugh et al., 2018), so it is possible that those diagnoses with a-typical AN might also experience an AV. Moreover, there is evidence to suggest that longer duration of illness is associated with a stronger AV (Pugh & Waller, 2016). Therefore, broadening the criteria was deemed both appropriate and expedient as the original inclusion criteria severely restricted the number of participants that could be invited to take part in the study.

Recruitment

Initially, two adult ED services in the UK were approached and agreed to be involved in the research study. However, a number of research commitments at one of the sites meant that no participants were eligible for invitation. Therefore, in the end, all of the participants were recruited from one service.

I was responsible for recruitment at the participating service. Potential participants were initially identified from consecutive referrals on service waiting lists, whose initial assessment suggested that they might be eligible to participate in the study. Those clients were sent the study's information sheet (Appendix 1), a 'consent to be contacted' form (Appendix 2) and the primary outcome measure. Those interested in taking part were invited to send me an email and I screened them over the telephone to see if they met inclusion/exclusion criteria. Participant eligibility was always checked with at least one other member of the research or clinical team (supervisors, therapists and/or service lead). Those that were deemed eligible to be

included in the study, and were still interested in taking part were then booked in for their first session. Participants were not offered any compensation for taking part in the study.

Power

Power is still uncertain within SCEDs (Arntz, Sofi, & van Breukelen, 2013). Morley (1996) suggests that SCEDs are more concerned with how many repeated outcome measure collections you make rather than how many participants are recruited. Existing SCEDs have typically recruited between four and six participants (Wells & Papageorgiou, 2001; Wells & Sembi, 2004; Shadish & Sullivan, 2011). Lanovaz and Rapp (2016) suggest a ‘three point’ guideline for determining experimental control of study designs. Taking into account the study’s time-frame, these recommendations, and potential participant attrition (approximately 40% in AN research, Bulik et al., 2007) this study aimed to recruit ten participants.

Design

The study employed an A-B single case experimental design (SCED), where phase A was baseline before the intervention and phase B was the intervention. Individual baselines acted as control periods. During phase A participants emailed me the primary outcome measure (The Experience of Anorexic Voice-Questionnaire, EAVE-Q; Gant et al., 2018) once a week for three weeks. Participants did not receive any treatment during their baseline period and communication via the telephone did not contain therapeutic manipulation. Phase B, the intervention phase, lasted six weeks and comprised of six, weekly, face-to-face sessions, with each treatment session lasting up to 60 minutes. All participants were asked to participate in a follow-up, semi-structured, interview one week after finishing the intervention and at the end

of treatment, all participants went back on the service waiting list for treatment delivered at the usual frequency.

Therapist and Training

I served as the only therapist in the study. Before starting the intervention, I participated in basic EFT training (emphasising client-centred principles and two-chair dialogue work) facilitated by my supervisors (JF and MP), totalling approximately 30 hours of training. The training included several experiential workshops that involved viewing video-taped sessions and role plays. During the therapy phase, I received supervision, whenever necessary. As a minimum, I met with my supervisors via 'Skype' once a week for clinical supervision. During these supervision meetings, audio-taped sessions were also reviewed to ensure proper implementation of EFT. Clinical supervision was also provided by the clinical lead at the ED service whenever requested.

Intervention

The intervention consisted of six one hour, weekly sessions. The treatment manual (Appendix 3) was designed by the research team (Pugh, Hibbs & Fox, 2018) and applies the general principles of emotion-focused therapy (Greenberg & Paivio, 1997) to working with the AV, incorporating similar techniques to those used in EFT (Greenberg et al., 1993).

Session one. Written informed consent was obtained at the start of the session (Appendix 4). Participants understood that they were free to withdraw from the study at any point. If consent was given, sessions began by starting audio recording for later rating. The focus of the first session was to assess the AV: its onset, intensity, frequency, triggers and content. Participants were also given psycho-education about

the AV. The therapist focused on therapeutic engagement in session one by focusing on the relationship and rapport between therapist and participant. The therapist attempted to make sure that the participant felt safe and validated. At the end of every session, therapist and client collaboratively wrote out the ‘Main Themes’ of the session and the most important take away points. Finally, therapists introduced participants to outcome measures that they would need to complete throughout the study duration. They were then given relevant baseline measures to take home with them and return to their next treatment session.

Session two. The focus of session two was to assess: motivation; participant’s style of relating to the AV; and the AV’s perceived functions. This was done by conducting a two-chair simulated interview with the AV. The exercise was designed to explore participants’ attitudes towards their illness and their voice, as well as inform the formulation. At the end of session two the therapist drew up a dialogical formulation.

Sessions three and four. The aim of these sessions was to start changing participants’ relationship with the AV, either by ‘softening’ the AV or by encouraging more assertive responding to the AV. The session focused on more dialogical work with the AV, principally using a two-chair technique for self-interruptive splits as developed in EFT (Shahar et al., 2011). The participant was asked to change chairs and enact their AV in the third person (“You are...”). After a period of expression the participant was asked to switch seats and express how it felt to receive such attacks.

Session five. The aim of session five was to build a more compassionate way of self-to-self relating. The session focused on finding a soothing voice/dialogue/warm presence to self-soothe, soften the AV and help regulate the

participants' emotions. The participant was asked to change chairs and enact their 'compassionate voice' in the third person ("You are..."). After a period of expression the participant was asked to switch seats and express how it felt to receive such compassion. Participants were asked to write 'goodbye letters' to their AV and bring it with them to the final session. The therapist also wrote goodbye letters to the participants summarising the work.

Session six. The aim of session six was to bring the work together by integrating information from therapy experiences into a new view of the self and the AV. Participants were asked to change seats and read their goodbye letters to the AV. The participants were then encouraged to elaborate how the AV affected their life, their intent to change the relationship and the steps they will take to achieve this. In addition, the therapist read goodbye letters to the participants. At the end of the session the participants were given a handout titled: 'Beginning to build a life without the AV' (see Appendix 5).

Since participant distress/emotion was being induced so that it could be worked with in the room, anxiety management strategies such as detached mindfulness (see Appendix 6) and coping flashcards (see Appendix 7) were used throughout the treatment to help regulate emotional intensity.

Measures

Psychopathology measures. The following measures (Appendices 8 to 10) were administered pre- and post-treatment:

The Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Appendix 8). The EDE-Q is a 28-item measure derived from the Eating

Disorder Examination (EDE; Fairburn & Cooper, 1993). The EDE-Q has four subscales: restriction, weight concerns, shape concerns and eating concerns. Internal consistency in the EDE-Q has been shown to be good, with Cronbach's α ranging from 0.70 to 0.83 in a clinical sample and from 0.78 to 0.93 in a general population sample (Luce & Crowther, 1999; Peterson et al., 2007). The EDE-Q has good reliability and validity (e.g. Mond, Hay, Rodgers, Owen & Beaumont, 2004).

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983; Appendix 9). The HADS identifies and measures severity of depression and anxiety. It consists of 14 items, seven of which measure depression, the other seven anxiety. Internal consistency in the HADS has been shown to be acceptable, with Cronbach's α ranging from 0.80 to 0.93 for the anxiety subscale and 0.81 to 0.90 for the depression subscales (Hermann, 1997). The HADS has good discriminant and concurrent validity (Herrmann, Buss, & Snaith, 1995).

The Pros and Cons of Anorexia Nervosa Scale (P-CAN; Serpell, Teasdale, Troop & Treasure, 2004; Appendix 10). The P-CAN is a 41-item decisional balance scale that assesses the perceived benefits and burdens of change. Eight subscales assess the perceived advantages of the AN symptoms which are summed to yield a 'Pro' score. Six subscales index the perceived disadvantages, which are summed to form a 'Con' score. Psychometric properties of the P-CAN are acceptable, with Cronbach's $\alpha = 0.68-0.86$ and a test-retest reliability of $r_{tt} = 0.60-0.85$ (Serpell et al., 2004)

Standardised measures.

Standardised self-report measures (Appendices 11 to 13) were collected weekly during the intervention phase to assess limited efficacy:

The Experience of Anorexic Voice-Questionnaire (EAVE-Q; Gant et al., 2018; Appendix 11). The EAVE-Q has recently been developed and measures the presence and significance of an AV in AN. Psychometric properties of the EAVE-Q have been found to be good, with Cronbach's $\alpha = 0.83$, test-retest reliability was moderate and construct validity was good (Gant et al., 2018).

The Brief Illness Perception Questionnaire (Brief IPQ; Broadbent, Petrie, Main & Weinman, 2006, Appendix 12). The Brief IPQ is an eight item scale assessing the cognitive and emotional representations of the illness. A total score represents the degree to which the illness is perceived as threatening or benign. Higher scores reflect a more threatening view of illness. The brief IPQ has shown good test-retest reliability and concurrent validity (Broadbent, Petrie, Main & Weinman, 2006).

The Eating Disorder-15 (ED-15; Tatham et al., 2015; Appendix 13). This 15-item questionnaire assesses ED cognition and behaviours, with subscales for weight and shape concerns and for eating concerns. Higher scores indicate greater disordered eating pathology. The ED-15 has strong reliability and validity in nonclinical populations (Tatham et al., 2015).

Motivation to change. Participants were asked to rate how motivated they were to change on a Likert scale of 0 ("not at all") to 10 ("completely").

Hope of recovery. Participants were asked to rate how hopeful they were of recovery on a Likert scale of 0 ("not at all") to 10 ("completely").

Qualitative Data Collection

One week post-intervention I conducted face-to-face follow-up interviews with each of the participants. The interviews were semi-structured using an interview schedule developed by the research team (see Appendix 14). The aim of the interviews was to gather information on what participants thought of the intervention, including feedback on how they experienced the intervention; what has changed and what has stayed the same in terms of their AV; and any suggested changes or improvements to the intervention. The interviews lasted approximately 25-30 minutes.

Ethical Approval

The study was reviewed and approved by Royal Holloway University of London Research Committee (Appendix 15). The London Bloomsbury Research Ethics Committee gave approval for the study (17/LO/0775) on 29/06/17. Approval was subsequently given by the NHS Health Research Authority (HRA), relevant local Research and Development (R&D) teams, and The Royal Holloway University Department Ethics Committee self-certification was obtained. Approval documentation for one non-substantial and two substantial amendments can be seen in Appendices (16 to 18).

Treatment Fidelity

To reduce threats to the study's validity, the research team measured my competency to deliver the intervention. Once all interventions were completed, my supervisors and I used the Carkhuff and Truax empathy scale (Truax & Carkhuff, 1967; see Appendix 19) to assess empathic attunement in all sessions that did not contain the two-chair dialogue for conflict splits (Sessions 1, 2, 5 and 6). The research

team used an adapted form of Greenberg's adherence measure for two-chair dialogues (see Appendix 20) to assess adherence to the central EFT task intervention (two-chair dialogue tasks; sessions 3 and 4).

Data Analysis

Descriptive statistics were used to describe the sample. Recruited participants, treatment retention and treatment adherence were described in order to consider treatment fidelity.

A thematic analysis of the follow up interviews was performed in order to investigate the acceptability of the treatment. Thematic analysis (Braun & Clarke, 2006) was chosen as the method of qualitative analysis because it aims to identify common themes in data relating to participant experience informed by the data, without any prior assumptions due to the limited amount of research in this area. The aim of the interviews was to gain feedback on participant's experience of using the intervention and as such, this method was deemed most appropriate. The analysis was completed in accordance with methodological guidelines outlined by Braun and Clarke (2006).

Finally, visual analyses (Morley, 2015) of weekly measures were carried out in order to establish limited efficacy of the intervention. Wilcoxon signed-rank tests were used to explore changes in psychopathology measures and Likert scales over time. Statistical analyses were performed using SPSS, Version 21.

Results

Feasibility

Treatment recruitment rate. A total of six participants (five female, one male) were recruited between October 2017 and December 2017; one participant every eleven days. From the sample approached ($n = 27$), only 22% ($n = 6$) went on to take part in the study. Eight participants contacted me and were screened for eligibility. Of those who qualified for being included in the study ($n = 7$), six (86%) consented to taking part, indicating a high uptake of suitable participants. One client was not deemed to be eligible as she did not experience an AV and one eligible client declined participation due to being unable to attend weekly sessions due to work commitments.

Participants' demographic and clinical information. The demographic and clinical characteristics of participants recruited into the study can be seen in Table 4. The sample was heterogeneous. The mean age was 35.75 (standard deviation [sd] = 6.73, range 26 - 55) and participants were from a range of ethnic backgrounds. The mean duration of illness was 16.25 years ($sd = 9.12$, range = 1 year - 39 years). All but one participant had experienced previous inpatient admission for AN. Two of the participants were in long-term relationships and two of the participants were single. Three of the four participants reported co-morbid symptoms of anxiety and one of the participants reported co-morbid symptoms of depression. All participants had previous diagnoses of AN (American Psychiatric Association, 2013) and remained psychologically symptomatic (validated by clinical notes).

Table 4: Participant demographics.

P	Sex	Age	Ethnicity	Marital status	Employment status	BMI	Length of illness	Comorbid symptoms
1	M	27	Asian British	Single	Employed	19.9	1 year	Depression
2	F	55	White British	In a relationship	Unemployed	16.7	39 years	Depression/ Anxiety
3	F	26	White Scandinavian	Single	Employed	17.7	2 years	Anxiety
4	F	35	White British	Married	Unemployed	16.9	23 years	Anxiety

Treatment duration and retention. Four out of the six participants who consented to take part in the research study received all six sessions of the intervention and were considered treatment completers. One participant dropped out of the study following her assessment due to a change in life circumstances and one participant dropped out of the study after three sessions due to a bereavement.

Treatment fidelity. All participants consented to having their sessions recorded and therefore, every session was rated. Acceptable competency standards were demonstrated as the mean empathy score was 3.7 ($sd = 0.08$) and the mean adherence score was 3.7 ($sd = 0.07$), both of which exceeds the satisfactory threshold.

Acceptability

Follow-up interviews. All of the participants who completed the intervention took part in the follow-up interview, which I digitally recorded and later transcribed. Once I had familiarised myself with the transcriptions, 110 initial codes were generated which were then searched and grouped into 13 separate themes. I then reviewed these and they were collapsed into five sub-themes under one broad theme. Defining and naming them was the final step before producing the report. The broad theme was named: ‘acceptability’ and the five sub themes were named: ‘changes in awareness of the problem’; ‘changes in relationship with the AV’; ‘specific helpful

aspects of the intervention'; 'challenges to using chairwork to work with the AV'; and 'overcoming challenges to using chairwork to work with the AV'.

Themes were identified at a semantic level and did not go beyond what participants said during the interviews. At all stages of the analysis, themes were discussed and confirmed with my supervisor (JF). In addition, a sample of two interviews were given to a colleague (AT) outside of the research team to cross-validate with the final themes. After discussion between the researchers, 100% agreement was attained.

Acceptability.

Changes in awareness of the problem. Participants said that the intervention helped them become more aware of their difficulties ("It made me realise exactly how much my brain is following those sorts of thought patterns all the time, just because a lot of the time, I'm so used to it I don't notice it" P1) and they talked about how this affected their motivation to change ("What has changed is mostly the motivation, the insight" P4). Participants discussed how the intervention had not led to any concrete behaviour change but pointed out that despite this, the intervention increased their awareness of the problem ("My defaults and bad habits are not, haven't really changed much but I feel like I'm a lot more aware of them" P3; "I think most things have stayed the same... just kind of feels like a plaster's been lifted, now you can see the, I'm not papering over the cracks anymore" P2).

Changes in relationship with the AV. Frequently, participants described changes in their relationship with the AV ("[the AV] has adapted...it feels like I'm a bit more free in my choice" P2). Participants discussed how the intervention had not changed the content of the AV, but their reactions to the AV had changed ("The

[AV], it still says the same things... but I've been able to kind of tune it out, not completely tune it out but tone it down. It feels like it's dominating my life less than it was before" P3; "I don't think I've changed the thought patterns very much...but a few times I have thought well this is like in the sessions and, you know, tried to sort of think of it as not the only way to look at things" P1). Finally, participants talked about having acquired more skills and motivation to change their relationship with the voice ("The voice is still doing what he/she does. I just have more tools to combat it. Now I'm more interested in combatting it" P4).

Specific helpful aspects of the intervention. Participants made positive comments about the emotion-focused aspect of the intervention ("Just being forced to actually put feelings into words... I've never done that before and it's all very obvious things and it's not related directly to the eating disorder but just kind of makes me feel a bit more whole" P3) and also about certain therapeutic tasks ("The letter you wrote me was incredibly meaningful and summarised really well the treatment journey. I have referred to it several times since and know that it will continue to be a useful resource" P4). Participants talked about how the intervention was unlike any treatment they had tried previously ("I've been through the story of how it started so many times over the years...but this did feel like it was not just repeating it like that, it was looking at it in quite a sort of serious way, looking at what it means now rather than just the same old story that gets told again and again" P1; "I was actually pleasantly surprised. There was a bit of scepticism from me...because I felt like I've kind of done stuff like this before" P2).

Challenges to using chairwork to work with the AV. Occasionally, participants struggled to identify with a voice ("It was definitely not something I identified with

before, and I still don't think I do" P3) and even when they could, participants discussed difficulties with externalising the AV ("I found that really, really hard because it does feel as though it's part of me most of the time so externalising it was hard" P2). Some participants reported finding it weird working with the AV ("It felt very strange...very forced" P3) and awkward to use chairwork ("I always find those things a bit awkward because I'm not a very outgoing person" P2). Some of the participants discussed how difficult it was to challenge the AV ("Challenging it was, I can't think of the word, well it felt unsafe, it felt like an unsafe thing to do" P2) and one participant was unsure whether the chairwork made any difference to her ("I don't actually know how much of a difference it makes to be moving chair to chair" P3).

Overcoming challenges to using chairwork to work with the AV. Despite reporting the above challenges, participants also discussed how talking with the AV got easier/more comfortable as the intervention went on ("I remember the first time or the first couple of times I found it a bit weird...and then the other times it became expected and it does actually help with the splitting the association part" P2; "It was a bit challenging to get in to but as it went on, I could see that there was, if I related to it a bit differently, if I related to it as a part of me it felt easier, I didn't feel as awkward anymore" P3).

Moreover, usually participants said that the intervention's helpfulness overpowered any difficulty. ("It was difficult but I think it was worth doing, it was definitely worth doing" P1; "Just for a second being able to be in one mind-set, rather than being constantly conflicted. That was the most helpful thing" P2; "I found it useful because it kind of gave you a way...of boxing up thoughts and feelings and

starting to untangle some, yeah, the untangling process” P3; “I really believe that this treatment would benefit lots of people should this be rolled out. I would highly recommend it to anyone struggling to move forward” P4).

Efficacy

This section of the results describes individual visual analysis of idiographic measure data. Visual analyses were conducted to consider the pattern of individual participants’ data over the duration of their involvement in the study. Although sometimes considered an insensitive method (Harper, 2002), the use of visual analysis is becoming increasingly widespread in clinical trials as it clearly enables the identification of effective interventions (Kazdin, 1998). Guidelines for visual analysis were followed (Kratochwill, et al., 2013), including that baselines will be considered stable enough to determine intervention effects when 80% of baseline phase data fall within a 20% range of the median (Gast & Spriggs, 2010). Idiographic data were graphed on x-y plots using Microsoft Excel (according to standard presentation of multiple baseline SCEDs) and can be seen in Figures 2 to 13. Raw data were graphed using solid lines and black square markers. Study phases have been separated by dashed vertical lines.

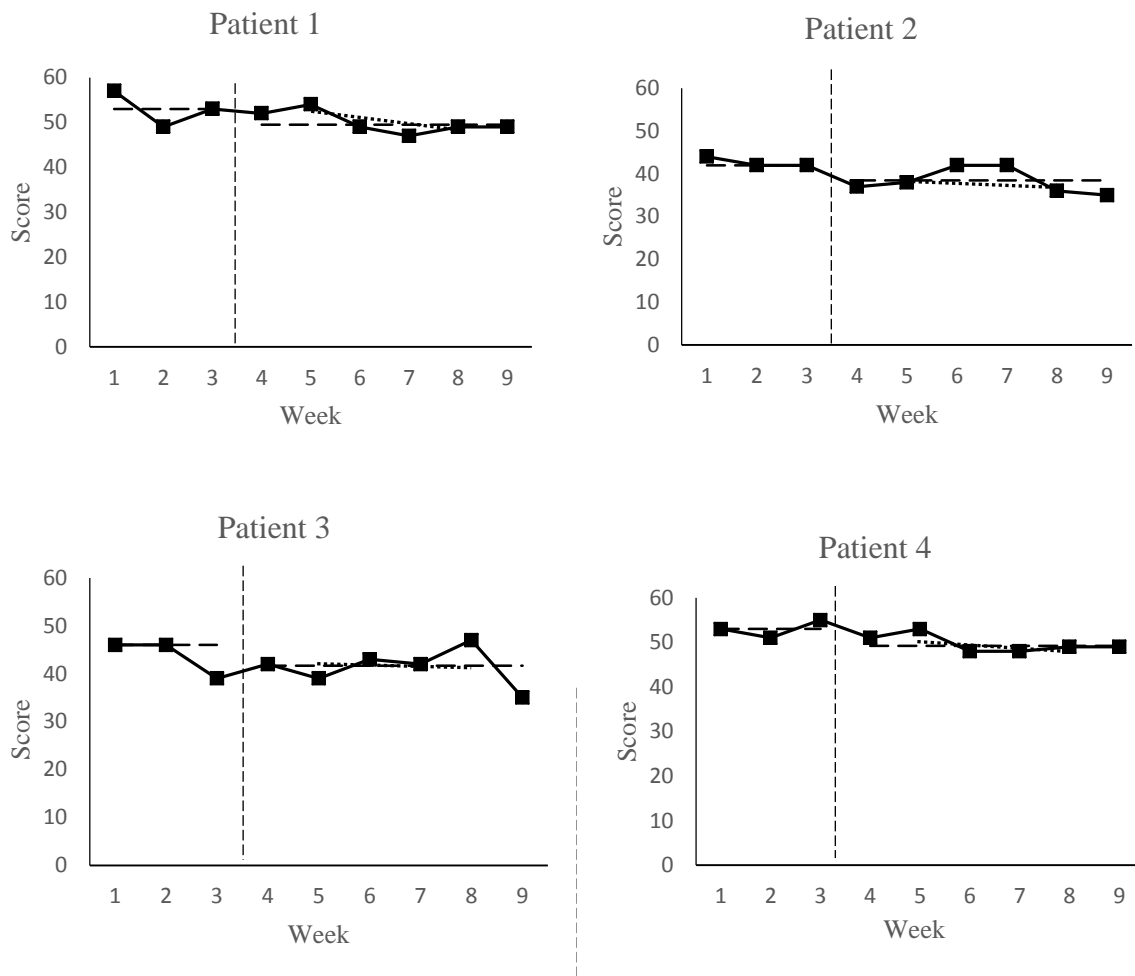
In order to assess change between study phases on the EAVE-Q, changes in the central tendency were investigated. In order to assess change within the intervention phase, the trend of all idiographic measure data were investigated. Different calculations of central tendency and trends were chosen according to Morley’s guidelines (Morley, 2015). Definitions of key terms used within this section, and when they were calculated are given below (see Table 5).

Table 5: Explanation of key terms calculated within visual analysis.

Type of measure	Key term	Explanation	Phase length	Depicted graphically by
Central tendency	Median	The middle value of rank ordered data	3	Dashed horizontal line
Central tendency	Broadened Median	The average of four middle values (the central two numbers are weighted by 1/3 rd and the outer 2 by 1/6 th)	6	Dashed horizontal line
Trend	Running median of 6	The average of successive sets of 6 data points throughout a phase, used to investigate systematic shift in central location over time, when data are highly variable	6	Dotted line

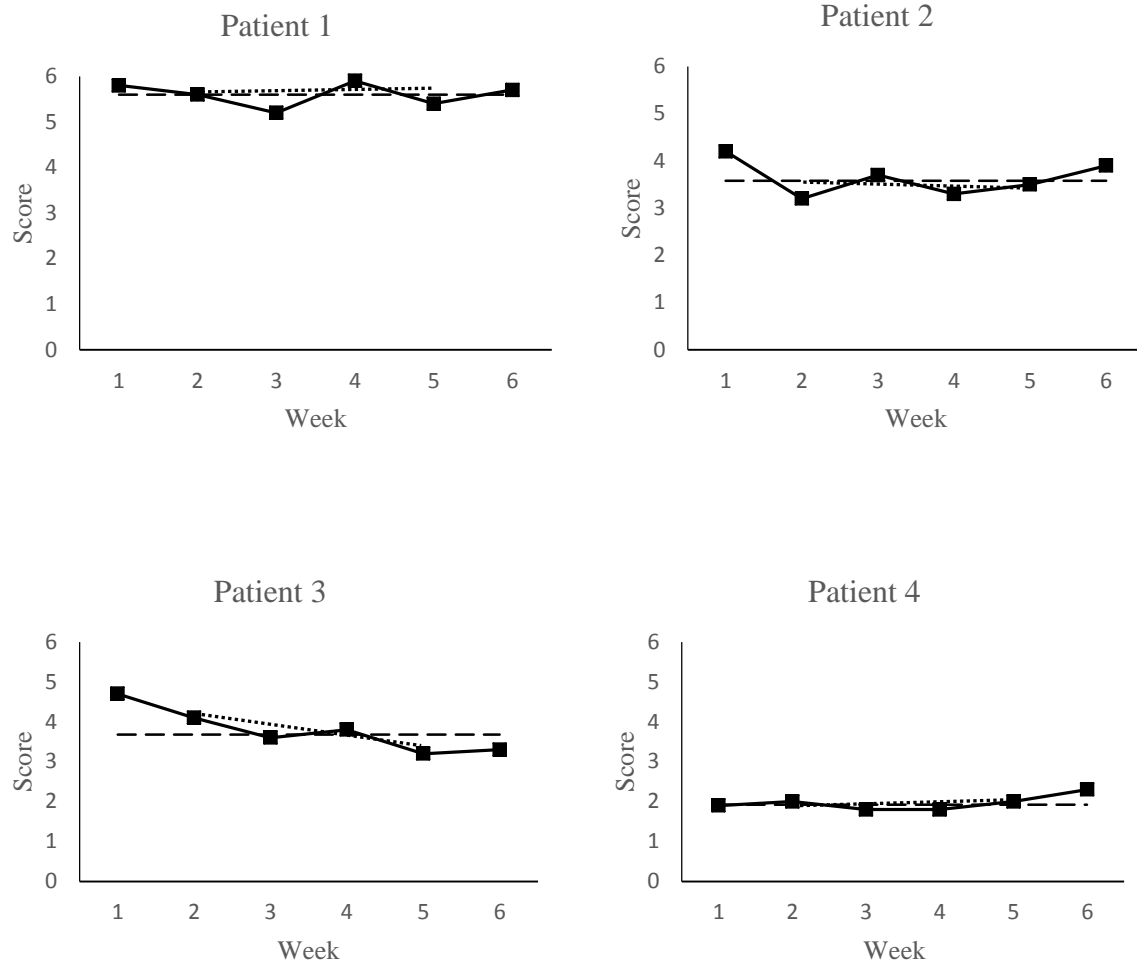
Figures 2 to 13 display participant outcomes. All of their EAVE-Q scores demonstrated baseline stability (Gast & Spriggs, 2010). The running medians and broadened medians are sometimes not visible on graphs, where they are the same as raw data values.

EAVE-Q



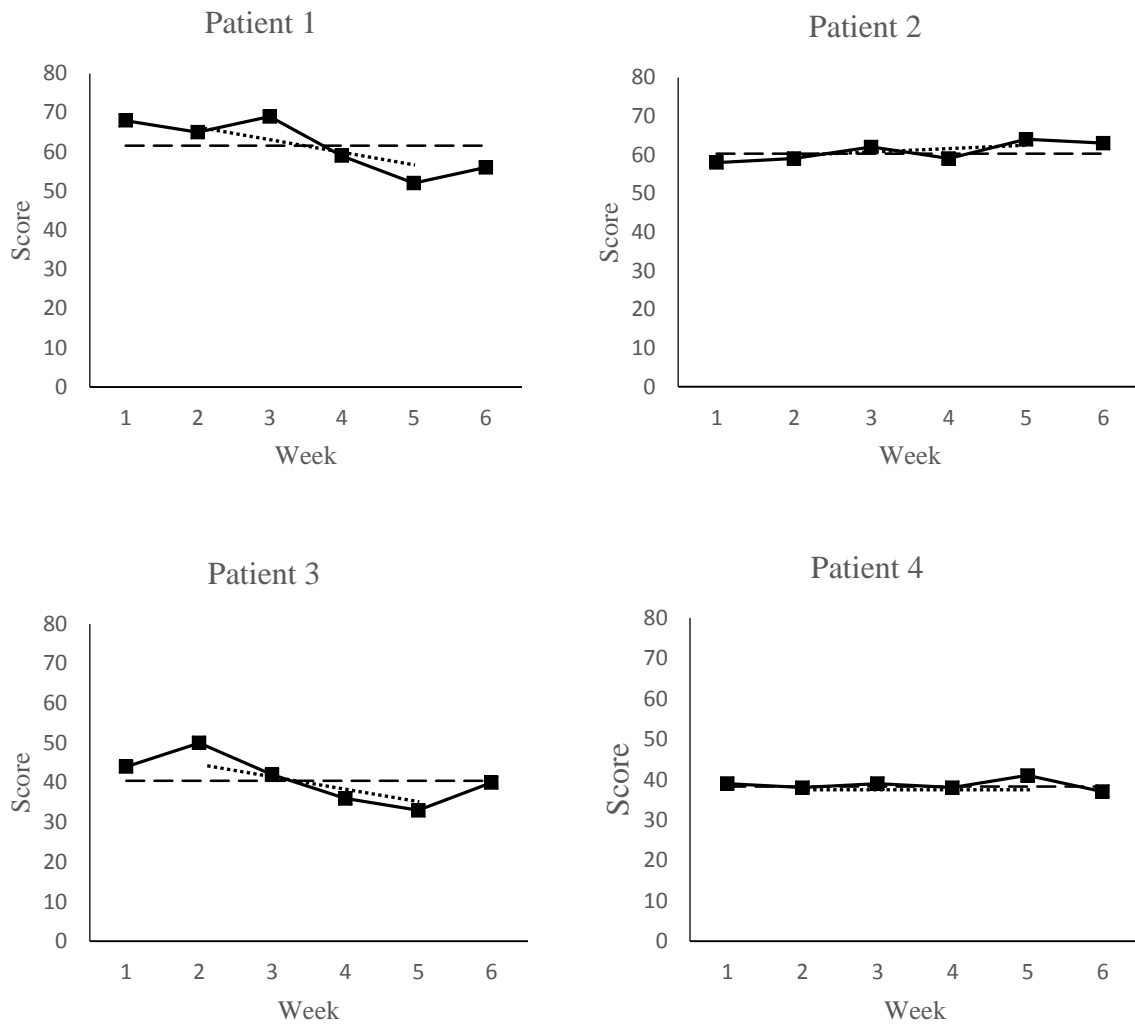
Figures 2 to 5, EAVE-Q scores during baseline and treatment

ED-15



Figures 6 to 9, ED-15 scores during treatment

IPQ



Figures 10 to 13, IPQ scores during treatment

Participant one (P1). P1 was a 27-year-old single man with a BMI of 19.9. He had a two year illness history. In March, 2017, he had a two month inpatient admission and received outpatient treatment for six months post-admission. When he started the brief EFT-AV intervention, his weight had improved to within normal range, but his EDE-Q scores placed him in the clinical range, giving him a current diagnosis of atypical AN. He had no psychiatric history prior to the development of his ED. He described current symptoms of depression.

Lines of central tendency indicated that the extent to which he identified with, endorsed and experienced the AV decreased from baseline to intervention. A downward trend was also observed in the intervention phase. No clear trends were observed for his ED cognitions and behaviours. Within the intervention phase, a downward trend was observed for his IPQ scores, indicating that over the course of the intervention he developed a less threatening view of the illness.

Participant two (P2). P2 was a 55-year-old mother of one with a BMI of 16.7. She had a long standing history of AN. She was first diagnosed aged 16. Since the onset of her illness, she has received treatment as an outpatient and has had several inpatient and day patient admissions. P2 described comorbid symptoms of depression and anxiety.

Lines of central tendency indicated that the extent to which she identified with, endorsed and experienced the AV decreased from baseline to intervention. Within the intervention phase, a very slight downward trend was also observed. A very slight downward trend was observed for her ED cognitions and behaviours. Within the intervention phase, a very slight upward trend was observed for the IPQ,

which could indicate that over the course of the illness she developed a slightly more threatening view of the illness.

Participant three (P3). P3 was a 26-year-old single woman with a BMI of 17.7. She presented with a two-year history of AN. She had not previously presented to services or had any treatment for her ED. She described co-morbid symptoms of anxiety.

Lines of central tendency indicated that the extent to which she identified with, endorsed and experienced the AV decreased from baseline to intervention. Within the intervention phase, a very slight downward trend was observed on the same construct. Within the intervention phase, a downward trend was observed for her eating cognitions and behaviours. Within the intervention phase, a downward trend was observed for the IPQ, suggesting that over the course of the intervention she developed a less threatening view of the illness.

Participant four (P4). P4 was a 35-year-old married mother of two with a BMI of 16.9. She had a long standing history of AN. She was first diagnosed when she was 12-years-old. Since the onset of her illness she has had three inpatient admissions and seven years of outpatient treatment. P4 described comorbid symptoms of anxiety.

Lines of central tendency indicated that the extent to which she identified with, endorsed and experienced the AV decreased from baseline to intervention. Within the intervention phase, a very slight downward trend was observed for the same construct. No clear trends were observed for her ED behaviours and cognitions. No clear trends were observed for her view of the illness.

Wilcoxon signed-rank tests showed that pre- and post-intervention results were non-significant for motivation to change ($z = -1.826$, $p = 0.068$) or hope of recovery ($z = -1.826$, $p = 0.068$). However, mean scores indicate a trend in improvements on these scales. For motivation to change, the mean score pre-intervention was $M = 3.38$ ($sd = 0.8$) and post-intervention it was $M = 5.81$ ($sd = 1.3$). For hope of recovery, the mean score pre-intervention was $M = 2.13$ ($sd = 1.09$) and post-intervention was $M = 5.38$ ($sd = 1.3$).

Psychopathology measures. Wilcoxon signed-rank tests were used to determine paired differences between data that were not normally distributed at two time points. The tests showed that there were no significant differences on any of the psychopathology measures pre- and post-intervention (see Table 6).

Table 6. Participants' psychopathology scores pre- and post-intervention.

	Pre	Post		
	Median			
Measure	Median (range)	(range)	z-score	p-value
HADS-A	15.5 (15)	16.5 (12)	-1.461	0.144
HADS-D	8 (20)	9.5 (19)	-1.633	0.102
EDE-Q	3.74 (3.48)	3.43 (3.76)	-1.095	0.273
PROS	-0.13(1.05)	-0.14 (0.7)	-0.365	0.715
CONS	0.83 (1.36)	1.13 (1.01)	-1.461	0.144

Discussion

The study employed a SCED and sought to explore whether a brief form of EFT, that focuses on the AV (EFT-AV), was (a) a feasible intervention for adult outpatients with AN; (b) perceived as an acceptable treatment by participants; (c) associated with improvements in: the relationship with the AV; beliefs about the

illness; ED cognitions and behaviours; and motivation to change and hope of recovery. This section summarises the key study findings in relation to the research questions and hypotheses and considers how the findings relate to existing literature in the area. Potential implications of the findings are then considered. Finally, strengths and limitations of the study are reported, and recommendations made for future research.

Recruitment, retention and treatment fidelity data have provided encouraging support for the feasibility of the intervention. First, all but one potential participants who met criteria for taking part in the study consented to participate. This indicates that the majority of eligible participants considered EFT-AV a credible and viable intervention. Second, four out of six (66.7%) participants were considered treatment completers and the two participants that did not complete treatment dropped out due to unforeseen personal circumstances. Since the circumstances for drop out were outside the control of the research team or intervention, this was considered to indicate high treatment retention. This finding is encouraging, especially when considering the evidence that attrition rates in AN treatment studies (Bulik et al., 2007) and emotion-focused treatments (Sala, et al., 2016) is approximately 40%. Thirdly, all of the audio recordings were rated for empathy and adherence and exceeded the satisfactory threshold for both. This finding not only demonstrated study feasibility, but also that the feasibility can be plausibly attributed to valid implementation of the intervention. Finally, the characteristics of the sample recruited show that the intervention was generally attractive to a heterogeneous sample.

Having said this, recruitment for this study was slow. There was a difficulty in finding participants who met the inclusion criteria and there was also a limited

response to the initial invitation letter, which could indicate low feasibility. However, the slow recruitment rate could also be attributed to the short recruitment period (three months) and problems with recruitment at the second recruitment site that were due to conflicting research priorities.

Participants' follow-up interviews provided encouraging support that EFT-AV is considered an acceptable treatment approach. The qualitative findings suggested that the emotion-focused aspect was valued by participants. This finding corroborates previous research that points to emotion-focused treatments being acceptable, feasible and effective for individuals with AN (Sala et al., 2016). Occasionally, participants struggled to identify with an AV and reported finding it difficult to externalise the AV. This is perhaps not too surprising as qualitative studies have highlighted the importance of the 'dualism' of AN as both a separate entity and as part of their identity (Higbed & Fox, 2010). Moreover, participants frequently talked about how this got easier over time suggesting that the treatment is challenging, but acceptable.

Participants frequently talked about how the intervention made them more aware of the problem, which improved their motivation to change. APA guidelines (2013) advocate the importance of therapy based on motivating someone with AN to change their behaviours and thoughts, further highlighting the acceptability of this intervention. In addition, participants reported changes in the relationship with the AV. This supports previous qualitative research that point towards including techniques in treatment that help clients manage their voice, which may always be present but could be something they learn to gain control over (Higbed & Fox, 2010).

This study was only designed to test the intervention in a limited way. However, visual analyses demonstrated that the extent to which all participants

identified with, endorsed and experienced the AV decreased from baseline to intervention and that this continued to decrease over the course of the intervention. In addition, one participant showed an improvement in ED behaviour and cognitions and two participants showed a decrease in their IPQ scores, indicating a less threatening view of the illness over the course of the intervention. Three out of four participants did not show any change in ED behaviour and cognitions and two out of four participants did not show any change in their beliefs about the illness. The pre- and post-intervention differences for motivation to change and hope of recovery were not significant but the results indicated trends in improvements on both these measures. Finally, there were no significant pre- and post-intervention differences on any of the psychopathology measures. In summary, the results from the quantitative part of this study indicate that participants can tolerate the intervention without exacerbating symptoms, which is encouraging.

Strengths

The present study is the first to design an emotion-focused therapy that focuses on the AV and test its application within an adult outpatient setting. Therefore, it makes an important contribution to the research field.

Sample. The recruited sample, though small, was heterogeneous in terms of gender, age, ethnicity, length of illness and previous treatment. This indicates that outcomes from the study apply to varying groups. Participation in the study was not incentivised by monetary compensation, potentially reducing selection bias.

Measures. Collecting a variety of repeated, valid and reliable, outcome measures increased the study's power, reliability and validity.

Design. The study was carefully designed to include a baseline phase to enable participants to act as their own controls and the achievement of stable baselines helped to demonstrate that changes in the relationship with the AV was due to the intervention. The intervention itself did not interfere with referral routes or waiting list durations as it was offered in addition to participants' usual treatment pathway. Moreover, the therapist was able to reliably adhere to the treatment, enhancing the study's external validity.

Limitations

This preliminary study has a number of important limitations. First, the generalisability of the effects of the intervention is limited by the small number of participants treated. Moreover, the sample was not likely to be representative of the target population because of the strict inclusion criteria and the fact that participants self-referred (and therefore, possibly made up of particularly compliant individuals). Investigations relaxing exclusion criteria (e.g. to include patients with other ED diagnoses such as bulimia nervosa) may have useful clinical implications to establish who will benefit from EFT-AV. Furthermore, the research took place within one ED unit. Conducting a similar investigation within a different unit or, preferably, a variety of services would be beneficial and enhance generalisability. The small number of participants also renders the inferential statistics that were used to examine pre-post changes across the group for the psychopathology variables inappropriate. A summary of the medians and ranges would have been more suitable.

Second, the outcome of treatment relied upon self-report measures that were handed to me upon completion, thus lacking objective and independent clinician-administered assessment. Therefore, it is possible that the reliability of the findings

has been negatively influenced by demand characteristics. Future investigations should add objective measurements, such as observational measures, clinical interview, or a report from other sources, such as a partner, which would achieve desirable multimodal assessment of outcomes and strengthen reporting of positive results. In addition, the delivery of treatment relied on one therapist, who was also the Chief Investigator (CI) for the study. This is problematic for two reasons. First, though I had approximately 30 hours of basic EFT training, I had not delivered EFT before in a clinical setting. Secondly, experimenter bias could have limited the reliability of the study measurements.

Finally, the measurement of treatment fidelity was also subject to bias, since although all of the audio recordings were rated, one of the raters was the CI who carried out the intervention. Process measurements were also not included in the study. It would also be useful to include these in future studies so as to provide evidence that the process hypothesised to be affected by the intervention actually changed.

Clinical Implications

The results from this study indicate that EFT-AV may be a feasible and acceptable intervention for some adult outpatients with AN. Results indicating that motivation to change and hope of recovery improves over the course of the intervention suggest that perhaps the intervention is best considered as a modular intervention, either as a preventative ‘top up’ intervention for relapsing/treatment-resistant individuals, or even as part of a pre-intervention where a focus on client’s motivation to change is required before commencing a ‘change-focused’ treatment (e.g. cognitive behavioural therapy).

Recommendations for Further Research

As this study was exploratory, it provides a starting point for research that is intended to be developed into larger experiments. Future research should aim to rectify the limitations of the current study. Such findings could then be used to guide the development of an optimised emotion-focused intervention that focuses on the AV. In the longer-term, an adequately powered RCT should be conducted to determine the efficacy and cost-effectiveness of EFT-AV in comparison to control and/or recommended active control conditions (e.g. weekly CBT-E for AN).

Conclusions

In summary, the current study provides new and tentative evidence highlighting the potential of a brief EFT intervention that focuses on the AV as a feasible and acceptable intervention for some adult outpatients with AN. This study adds to the growing literature implicating the need for treatment approaches to incorporate this phenomenological aspect of AN. Moreover, the findings of this exploratory study now warrant further evaluations in a pilot study to substantiate its results, identify treatment effects, and the conditions under which the intervention will be optimally effective.

Integration, Impact, and Dissemination

This section provides a synthesis of different aspects of the thesis, considers the potential real-world impact of what was found and how to maximise this, and outlines steps that will be taken to disseminate the findings.

Integration

Summary and Integration of the Systematic Review and Empirical Paper

My systematic review investigated the effectiveness of emotion-focused chair-based interventions for adults with mental health difficulties. The empirical study examined whether a brief form of emotion-focused therapy that focuses on the ‘anorexic voice’ (EFT-AV) was feasible and acceptable as an intervention for adults with anorexia nervosa (AN). The review provides tentative evidence that emotion-focused chairwork techniques might alleviate psychological distress in individuals with depression, anxiety, self-criticism, partnership ambivalence, lingering feelings towards a significant other and histories of childhood abuse and the results from the empirical study indicate that EFT-AV may be a feasible and acceptable intervention for some adult outpatients with AN. The link between the two studies is that they both investigated the use of emotion-focused chairwork interventions in clinical settings. In this way, they both provide information for researchers and clinicians interested in the use of emotion-focused chairwork techniques in therapy.

In some ways, however, it is difficult to make comparisons between the two studies. The systematic review did not include any studies that examined the use of chairwork with clients with eating disorders (EDs). One of the main suggestions for future research was to determine whether and how chairwork is effective for disorders other than those included in the review. Furthermore, the studies in the systematic

review employed a variety of emotion-focused chairwork techniques (two-chair dialogues for self-evaluative splits; two-chair dialogues for self-interruptive splits; empty-chair dialogues for lingering feelings; and empty-chair dialogues with the perpetrator[s] of abuse), whereas the intervention being tested in the empirical study employed one specific form of chairwork (two-chair dialogues for self-evaluative splits). Due to the variety and lack of clear definition of the chairwork techniques used in the studies in the systematic review, suggestions for future research highlighted the importance of addressing the extent to which the different chairwork techniques are responsible for improvements in outcomes and establishing who responds best to the interventions.

The review provided a conceptual basis for the empirical study as it highlighted the potential of emotion-focused chairwork techniques for alleviating psychological distress in clients with a variety of mental health difficulties. Moreover, the small number of studies included in the review also revealed the lack of empirical investigations of emotion-focused chairwork techniques. There were no studies that included a clinical sample of people with EDs which indicated a gap in the literature – to determine whether and how chairwork is effective for people with EDs.

In addition, limitations found in the studies in the review helped to inform and shape how the empirical study was carried out. For example, the review indicated the need for clearly defined interventions. In some of the studies in the review it was not always clear what or how much of the intervention was being used. The impact being that it was difficult to merge the findings and identify precisely what was differentially effective. Therefore, in my empirical study, I took care to ensure that I stated clearly what intervention was used and how often. In addition, the review

highlighted the lack of generalisability across many of the studies included in the review. In general, populations in the studies included predominantly Caucasian females aged 26-46, thus limiting inferences about the effectiveness of chairwork for other client demographics. This finding made me aware of the need for a heterogeneous sample in the empirical study and in the end the recruited sample, although small, was heterogeneous in terms of gender, age, ethnicity, length of illness and previous treatment. Lastly, the review highlighted the importance of treatment fidelity. On the whole, the investigators in the studies in the review recorded sessions and assessed treatment fidelity implying that results from those studies can be plausibly attributed to valid implementation of the intervention. Therefore, every session was audio recorded in the empirical study and every session was rated by two members of the research team.

Unfortunately, there were some limitations highlighted in the systematic review that it was not possible for me to address in the empirical study and therefore remain aims for future research. For example, many of the studies in the review reported low sample size as a major limitation to generalisability. The sample size in the empirical study was very small ($N = 4$) and in addition, participants self-referred from one ED unit in the UK and therefore (as with many studies in the review) were not likely to be representative of the target population. As such, I have highlighted in my discussion of the empirical study the importance of further evaluations in a much larger pilot study to substantiate results. Furthermore, all the studies in the review, and echoed in my empirical study, relied solely on the use of self-report measures. Future research should address this limitation by adding objective measures such as observations and clinical interviews to strengthen the conclusions that can be drawn

from positive results. Finally, it was beyond the scope of the review to examine mechanisms of change in emotion-focused chairwork interventions. However, in discussing the results of the systematic review I argued that the efficacy of chairwork can be more reliably implicated as the active ingredient in studies where EFT with chairwork was compared with person-centred therapy or empathic exploration, or when chairwork was evaluated as a stand-alone intervention and compared against a more cognitive intervention. However, neither process measurements nor control conditions were included in the empirical study condition. Future studies are needed to clarify the mechanisms of change in EFT-AV.

Research Challenges and their Implications for the Project

Recruitment. Recruiting the required number of participants is integral to the success of clinical research. However, it is not uncommon that research studies fail to recruit their expected recruitment rate (McDonald, et al., 2006). Undesirably, my study was no exception. In my initial proposal, I planned to recruit ten participants to allow for a drop-out rate of 40%. However, by the end of the recruitment process I had only recruited 6 participants (which was 40% less than originally planned) and with the (anticipated) drop-outs my final sample size of treatment completers was four.

Looking back, perhaps my recruitment proposal had been ambitious, given the study's time-frame and scale. However, I have also reflected on, and identified, several factors that may have contributed to recruitment problems. Firstly, recruitment started later than had planned. There was a four month delay in obtaining ethical approval. It was an ambitious project testing a novel intervention on a risky client group. Naturally, it required careful consideration from the ethics board, which I

should have foreseen. What is more, once I eventually gained approval, I had to submit a minor amendment to include a cover letter in my recruitment packs which I had omitted from my ethics application. This oversight resulted in further delays in starting the recruitment process (i.e. completing eligibility assessments and starting the intervention).

In addition, recruitment was significantly slower than expected. Both of my supervisors were surprised at the slow rate of recruitment as it was not anticipated that participants would be difficult to recruit for this study. One of the possible reasons for this was that I could not recruit any participants from one of the two ED services where recruitment was intended. Unfortunately, this substantially reduced the pool of participants from which to recruit. According to Patel, Doku and Tennakoon (2003), building collaborative relationships with clinicians working in the recruitment sites may function to improve recruitment rates. In my study, it was indeed easier to establish relationships with the staff at the ED service where I was also on clinical placement. As I was on site three to four days a week I was able to ascertain who was interested in the research and who to liaise with on recruitment issues. I was not physically present at the second recruitment site (due to time pressures) and in hindsight this may have been a good idea so as to meet more of the staff face-to-face and engage them in the recruitment process.

As well as considering how best to engage clinicians, Patel, Doku and Tennakoon (2003) discuss how to engage participants. One suggestion that is relevant for this study is being as flexible as possible for participants in terms of appointment time, travel arrangements, and meeting in convenient locations. While I tried to be as flexible as possible, I was restricted to recruiting and running the intervention on two

specific days in one location between 9.00am and 5.00pm (to fit with University and clinical placement commitments). This was a barrier to recruiting some of the individuals I contacted. For example, one of the potential participants was working full time and another had physical health problems and therefore these participants could not attend due to the timings and location of the intervention.

Due to the slow recruitment rate, a substantial amendment was submitted which changed the recruitment process. Firstly, a follow-up telephone call was added so that participants who were sent the research packs could be contacted. The telephone call meant that I could: (a) check that participants had received the pack and (b) ask participants if they had any questions about the study. Telephone reminders have been implicated as an effective strategy for improving recruitment (Treweek, et al., 2013). In addition, as part of the same amendment inclusion criteria were relaxed to enable the recruitment of participants with a-typical AN and any episode. The advantage of these changes was that they increased the number of participants that could be invited to take part in the study. However, the disadvantage was a reduction to the methodological quality of the study. Broadening inclusion criteria to include a mixed sample of AN and a-typical diagnoses with a range of treatment episodes reduced the generalisability to either population. Since the study was exploratory, it was possible to be flexible in the methodology as it provides a starting point for a larger, well-controlled, pilot study. However, it was disappointing to have to make changes that compromised the design and methodological quality of the study because of recruitment problems.

Researcher bias. Bias is defined as anything that “prevents an unprejudiced consideration of a research question” (Pannucci & Wilkins, 2010, p. 619).

Regrettably, there were several potential areas of bias in both my systematic review and empirical project, which have important implications for the conclusions that can be drawn from either. It is my responsibility as a researcher (Simundic, 2013) to attempt to outline the potential sources of bias and the actions I took to try to minimise their impact. In the pursuit of transparency and accuracy, areas where bias was still present have been acknowledged in the respective discussion sections of each study.

For example, during the planning stage of the empirical project, it was agreed that I would conduct the post-intervention follow-up interviews. The rationale for this was that I knew the intervention and the therapy that had been delivered to each participant and therefore would be able to ask more sensitive and detailed questions. However, there was also a risk of bias because I had designed, implemented and evaluated the treatment intervention. Therefore, I attempted to enlist the help of my colleagues in conducting the post-therapy interviews. Unfortunately, there were practical limitations in finding clinicians to assist me. Clinical pressures at the ED service meant that none of my colleagues had time to assist me in collecting the data. In retrospect, I would have invested time at the start of the project establishing who might be willing to assist me in collecting data so as to reduce bias in this area of my research. In terms of the literature review, it could be argued that the results were influenced by research allegiance effects as it was carried out by a researcher planning to use emotion-focused chairwork in her own intervention. In retrospect, the risk of bias could have been reduced by enlisting the help of another researcher, with no involvement in the study, to perform the eligibility assessment, data extraction and quality assessment of the studies.

Professional and personal development. Looking back, I appreciate that this was an ambitious project. Practical difficulties, such as slow recruitment, continuously shifted the goal posts for this project. Moreover, a considerable amount of time was spent being trained in EFT and employing the intervention, leading to, at times, physical and emotional fatigue. In completing this project I have learnt the importance of believing in your research and maintaining motivation in the face of practical barriers and physical exhaustion. I was in the fortunate position of choosing a research project based on my specific area of interest and expertise. In addition, I received specialist supervision from Dr. John Fox and Dr. Matthew Pugh. Their valuable contributions and support enormously shaped both the development and the delivery of the project. Their enthusiasm for the project, combined with my own commitment to making a difference to the lives of people with EDs kept me going during the more challenging times. In addition, I have learnt to be aware of and manage my own ‘inner critic’ and harness my own compassionate voice during times of competing demands, not only from the research, but also from clinical placements, other academic work while trying to maintain some semblance of a personal life at the weekend and in the evenings!

Impact

Summary of Impact

It is estimated that the lifetime prevalence of anorexia nervosa (AN) is 1.2% in females and 0.29% in males (Bulik, et al., 2006). It is a difficult disorder to treat (Steinhausen, 2002) and there is a lack of clear evidence for effective therapies (Dare et al., 2001). My systematic review highlighted the potential of emotion-focused chairwork techniques for alleviating psychological distress in clients with a variety of

mental health difficulties. Qualitative research has identified the experience of an ‘anorexic voice’ (AV) in individuals with AN. Consequently, a brief emotion-focused therapy intervention that focuses on the AV (EFT-AV) was developed and it was found to be feasible and acceptable for some adult outpatients with AN. The systematic review adds to the empirical foundation of emotion-focused chairwork interventions and the empirical study adds to the growing literature implicating the need for treatment approaches to incorporate the AV. Further evaluations are now necessary to substantiate this project’s results, identify treatment effects and the conditions under which the interventions will be optimally effective.

Underpinning Research

Maintenance models for AN have centred around various intra- and interpersonal factors including the over-evaluation of shape and weight, pro-illness beliefs and maladaptive relationship patterns (Fairburn, Shafran, & Cooper, 1999; Schmidt & Treasure, 2006). However, in clinical practice, research has shown that a significant number of individuals with EDs do not improve following therapies based on these theories, with several studies showing that they are, at most, only equally effective as comparison treatments (McIntosh, et al., 2005; Schmidt, et al., 2012; Zipfel, et al., 2014). Ambivalence about engaging in treatment, the egosyntonic nature of symptoms and the denial of illness partly explain why changes are often difficult to achieve (Higbed & Fox, 2010). The AV provides a compelling formulation of the many challenges encountered in work with this clinical group (such as the egosyntonic nature of the illness). Emotion-focused therapy (EFT) is well suited for this work as it offers techniques (chairwork) for dealing explicitly with the AV. The systematic review was carried out in order to assess the clinical effectiveness of

emotion-focused chair-based treatment. EFT has been considered for the treatment of EDs (Dolhanty & Greenberg, 2009; Dolhanty & Greenberg, 2007) as EFT attempts to transform core maladaptive emotions into healthy emotion schemes, thereby rendering AN as unnecessary in coping with negative emotions. However, EFT had not yet been tested when applied to the AV. This study therefore developed such an intervention and tested it on four adult outpatients with AN.

Details of the Impact

Impact on academic researchers. The empirical study is the first to test an emotion-focused intervention that focuses on the ‘anorexic voice’. The results offer an important contribution to the literature, in an under-researched area (Pugh, 2016). Specifically, the finding that brief EFT-AV is both feasible and acceptable suggests that the AV is a phenomenon worthy of further investigation, both in terms of improving understandings of how AN is maintained and facilitating the development of novel interventions for AN that incorporate work with the AV. The empirical study highlighted areas of focus for future researchers in the field. For example, that evaluations are now warranted in a pilot study to substantiate results, identify treatment effects, and to determine the conditions under which the intervention will be optimally effective.

The systematic review is the first to examine the clinical effectiveness of emotion-focused chair-based techniques among empirical studies. The results offer some clarification in a somewhat ambiguous and incomplete field of research. Overall, the findings suggest that emotion-focused chairwork techniques show promise for reducing psychological distress in individuals with a variety of mental health difficulties. This finding informs on the empirical foundation and specification

of chair-based interventions. In the same way as the empirical study, the review has, crucially, highlighted the areas for further research. Results from the review indicate that more work is needed to: address the extent to which the chairwork techniques are responsible for improvement in outcomes; establish who responds best to these interventions and; determine whether and how chairwork is effective for disorders other than those included in the review.

Impact on UK AN treatment guidelines. AN is among the most difficult to treat of all psychiatric disorders (Halmi et al., 2005). There is a lack of clear evidence for effective therapies for AN and therefore, guidelines for treatment are tenuous and new approaches showing promise must be developed (Wilson et al., 2007). The empirical study has shown that a brief form of emotion-focused therapy that focuses on the AV is both feasible and acceptable as an intervention for some adult outpatients with AN. Significantly, symptom outcome measures indicate that clients can tolerate the intervention without deteriorating. In response to growing appeals for novel models of pathology which better engage clients and explain the persistence of EDs, this study suggests that brief EFT-AV is, at the very least, an intervention worthy of further investigation.

Impact on treatment implementation. Trends from the empirical study suggest that motivation to change and hope of recovery might improve over the course of a brief EFT-AV intervention. If this finding is substantiated in larger pilot studies or RCTs, it could indicate that EFT-AV should be used as a modular intervention, either as a preventative ‘top up’ intervention for relapsing/treatment-resistant individuals, or even as part of a pre-intervention where a focus on client’s

motivation to change is required before commencing a ‘change-focused’ treatment (e.g. CBT).

The systematic review has implications for the delivery of emotion-focused therapy. There were several studies where EFT with chairwork was compared with person-centred therapy or empathic exploration, or chairwork was evaluated as a stand-alone intervention and compared against a more cognitive intervention. The results from these studies suggest that chairwork is the active ingredient in emotion-focused interventions. However, the results are tentative as the interventions included in the review were varied and moreover, were not always clearly defined. Therefore, the systematic review also highlights that more work is needed to confirm and clarify the extent to which the chairwork techniques are responsible for improvement in outcomes in emotion-focused therapies.

Impact on the National Health Service (NHS). The cost of in-patient care for AN are amongst the highest of all psychiatric disorders (Green & Griffiths, 2014). Improving treatment outcomes for people with AN important to help lower costs for the NHS. The results from the empirical study indicate that EFT-AV may be a feasible and acceptable intervention for some adult outpatients with AN. Future research should use these findings to guide the development of an optimised emotion-focused intervention that focuses on the AV. In the longer-term, an adequately powered RCT should be conducted to determine the cost-effectiveness of EFT-AV in comparison to control and/or recommended active control conditions (e.g. weekly CBT-E for AN).

It is very much in the early stages of development but if results can substantiate findings that motivation to change and hope of recovery improve over the

course of the intervention then there is potential of using the intervention either as a preventative ‘top up’ intervention for relapsing/treatment-resistant individuals, or even as part of a pre-intervention where a focus on client’s motivation to change is required before commencing a ‘change-focused’ treatment (e.g. cognitive behavioural therapy). Preventing inpatient admissions and re-admissions would have a massive impact on the costs incurred by the NHS for treating AN.

Impact on Adults with AN. Clients with AN benefit from the development and delivery of novel treatments. Though exploratory at this stage, larger, well-controlled, pilot studies that substantiate the effectiveness of brief EFT-AV have the potential to improve upon the treatment of adults with AN. The empirical study has worked not only to improve the effectiveness of existing treatments but also disseminating best practice through my own training and continuing professional development.

Media and cultural organisations. It is hoped that, in time, there will be a more widespread understanding of the AV and its implications in the treatment of AN. This will be achieved through raising awareness of this research among a broad range of audiences and through creating dialogues with the media to inform our research priorities.

Publication and Dissemination

Publication and dissemination is an important way of evidencing and maximising the impact of this project. Work is currently underway to submit the empirical study for peer review at the ‘Journal of Consulting and Clinical Psychology’ and to submit the systematic review for peer review at ‘Clinical Review’. It is hoped

that results from the empirical study will also be submitted as a chapter in a book currently being written about the use of chairwork in psychological therapies.

In addition to publications, the results of this study have been disseminated via presentations to ED clinicians, trainee clinical psychologists and academics in the field of mental health. For instance, in April 2018 I spoke at a Clinical Improvement Group at the outpatient ED service where recruitment took place. I am also due to speak at a Continuing Professional Development meeting at a Child and Adolescent Mental Health Service (CAMHS) for EDs in June, 2018. In addition, in May 2018 I presented the research to trainee clinical psychologists and lecturers at Royal Holloway, University of London.

Lastly, an Abstract was submitted to the Eating Disorders International Conference and the results of the empirical study were presented by my supervisor, Dr. Matthew Pugh. Unfortunately I was unable to attend due to a last minute clinical placement commitment. However, another Abstract has been submitted to present results from the empirical study at the 'World Congress of Behavioural and Cognitive Therapies' in Berlin in 2019.

Conclusion

The research carried out for this thesis was challenging, stimulating and potentially interesting for the future of individuals with AN and their loved ones. It has impacted on me as both a researcher and a clinician working with people with EDs. Hearing clients' experiences of their AVs was insightful and fascinating, but also shocking and heart-breaking. As a researcher, I felt privileged to be the first to investigate this novel form of intervention in a very new area of research. As a clinician, I will continue to consider the possible impact of the AV on clients with

whom I go on to work. I also hope to incorporate my developing skills in emotion-focused therapy in the work I do with this client group. It is hoped that the research will soon be published and will contribute to the research and clinical field, in terms of implications for future research and practice.

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Appendices

Appendix 1

Information Sheet



IRAS Project ID: 219549

WORKING WITH THE ‘ANOREXIC VOICE’

Applying emotion focused therapy to the treatment of the ‘anorexic voice’ within anorexia nervosa: A brief intervention

You are being invited to take part in a research study. Before you decide whether you would like to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information.

NB: Unfortunately we are only recruiting six patients so participation will be on a first come, first served basis.

Thank you for your time and consideration.

What is the purpose of this study?

In summary, we want to investigate the effectiveness of working with the “anorexic voice” using a brief intervention for individuals experiencing symptoms of anorexia nervosa.

The anorexic voice is an internal dialogue which is different from more typical self-critical thoughts or auditory hallucinations. It is usually experienced as a second or third person commentary on thoughts and behaviours relating to weight and shape. Research has shown that over 90% of eating disorder sufferers describe hearing an anorexic voice and we want to help address this aspect of eating difficulties. We hope that this will help us to better understand the development and maintenance of an eating disorder and inform the way professionals working with these types of difficulties. By gathering more information in this way, more specific and effective treatment programmes can be developed.

Do I have to take part?

It is entirely up to you whether you choose to take part in this study or not. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. This will not prejudice you or affect your treatment in any way.

What will it involve?

We will ask you to complete the enclosed questionnaire weekly for three weeks before the intervention begins.

NB: This is to ensure that stable baselines are established before you take part in the intervention. If stable baselines are not established within this 3 week period, you would not be eligible to take part in the study.

For the intervention itself I will ask you to come to the [REDACTED] for 6 weekly 1 hour individual sessions with myself. During these sessions I will use an evidence-based form of psychological therapy called emotion focused therapy (EFT). EFT is an evidence-based psychological therapy that offers ways of dealing with harsh internal critical voices. EFT incorporates an experiential technique called “chairwork”, which we will use to facilitate communication with the anorexic voice. I will also ask you to complete some questionnaires in these sessions and at the end of treatment there will be a 30-60 minute interview asking for your feedback on the intervention. I will also be in touch with you 1 month after the end of the intervention to complete a follow-up questionnaire.

What are the benefits of taking part in the study?

In participating in this study we hope that you may gain a greater understanding of your anorexic voice and potentially see an improvement in your mood, anxiety and/or eating disorder symptoms. You are also providing valuable information that will help us understand eating disorders better. We will be able to use this information to discover how they develop and better ways to treat them.

What are the risks involved in participating?

As its name suggests, emotion-focused therapy is likely to evoke strong feelings and there is the potential risk of emotional distress. The specific potential risk involved in this study is that as you start to address your anorexic voice it may get worse before it gets better. It is possible that may have a negative impact on your mood and/or your eating disorder symptoms to begin with.

Several steps have been taken to minimise risks and burdens as far as possible. Firstly, flashcards with coping statements will be developed ‘in-session’ for you to use in the weeks outside of the sessions as form of support. Secondly, a named clinician at the [REDACTED] will be assigned to you should you required additional support. Thirdly, the

treatment is being timed so that you will see a clinician for 'treatment as usual' immediately following my intervention (so that you are not just put back on a waiting list for several weeks). Finally, I will receive fortnightly clinical supervision, part of which will involve discussing your safety and how any distressing side-effects you may experience can be minimised.

The other burden of participating in this study is your time. The sessions will last approximately 1 hour each and there will be six of them, plus travel time to the [REDACTED]. However, we hope that by taking part in this study you will gain a greater understanding of your anorexic voice and potentially see an improvement in your mood, anxiety and/or eating disorder symptoms. We also hope that this treatment will be a useful foundation for your later treatment with the [REDACTED].

Confidentiality

All the information you give us will remain confidential. We will record sessions on your electronic record, but these will only be accessible to clinicians involved in your care. If you consent, your sessions will be audio recorded using NHS compatible audio recorders that will be password protected. Audiotapes/audio files will be destroyed once transcribed. We will assign a numeric code to all the information we collect from you at the time we collect it from you, and your name and contact details will not be stored with the data. All raw data will be stored in locked storage units in a secure area of the [REDACTED] at [REDACTED]. Information will also be held on a computer database locked with a security password. One secure electronic document will link your name with your unique code. This document will only be accessible by the lead researcher.

Once the data has been assigned a code and separated from any personal details, it will not be identifiable except to the lead researcher, therefore we will analyse the results even if you choose to withdraw from the study. The information you provide us with will be kept at the University for five years in accordance with Royal Holloway, University of London guidelines. It will be stored and disposed of securely. In the case of an audit, the sponsor, Royal Holloway, may have access to personal data. In this case, all information will be kept confidential and handled with sensitivity. Where results are published or are presented at conferences, your name will not be mentioned and no identifiable information will be shared.

If you choose to withdraw from the study at any time, any identifiable data already collected with your consent will be retained and used in the study. No further data would be collected or any other research procedures carried out following your decision to withdraw.

Results of the study

The results of the study will be submitted for publishing to public journals. They will also be submitted as part of Rebecca Hibbs' DClinPsy thesis. Results may also be presented at conferences and/or submitted for publication within a research journal. In all instances, no names will appear and you will not be identifiable from the data presented.

Who is organising the research?

The research is being carried out for a DClinPsy project at Royal Holloway, University of London. The study has been reviewed by project supervisors and the DClinPsy review committee at Royal Holloway, University of London.

All research carried out in the NHS is reviewed by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by a national Research Ethics Committee.

What if something goes wrong?

If at any time you are unhappy about the way in which you have been approached or treated during this study, you are free to make use of the complaints procedures which are provided by [REDACTED]. You can contact the Complaints Office on [REDACTED] or email: [REDACTED]. All communication will be dealt with in strict confidence.

Further information

If you would like more information about this research please feel free to contact the lead researcher Rebecca Hibbs at: rebecca.hibbs.2015@live.rhul.ac.uk. You can also contact [REDACTED].

If you are interested in taking part in this study please return the enclosed 'consent to contact' form either by post, email or by bringing it to your next psychiatric appointment. Please keep this Information Sheet for your own records.

Appendix 2:
Consent to be Contacted Form



CONSENT TO CONTACT FOR RESEARCH PURPOSES

TITLE: Applying emotion focused therapy (EFT) to work with the ‘anorexic voice’ (‘AV’) within anorexia nervosa (AN). A proof of concept study.

SPONSOR: Royal Holloway, University of London

INVESTIGATORS: Dr. Rebecca Hibbs

You are being invited to give consent for Rebecca Hibbs to contact you at some time in the future to invite you to participate in a research study.

Are you willing to learn more about the anorexic voice study? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

☐ **Telephone:** _____

☐ **Email:** _____

This consent is effective immediately. Your consent to be contacted can be revoked by you at any time.

Patient’s Signature: _____

Date: _____

Treatment Manual

WORKING WITH THE ‘ANOREXIC VOICE’

Applying adapted emotion focused therapy to the treatment of the
‘anorexic voice’ within anorexia nervosa: A brief intervention

Six sessions, 1 hour each

Background and Aims:

Anorexia Nervosa (AN) is a serious, potentially life-threatening eating disorder (ED) characterised by self-starvation and excessive weight loss (American Psychiatric Association, 2013). It is among the most difficult to treat of all psychiatric disorders (Halmi, et al., 2005), and a lack of clear evidence for effective therapies (Dare, Eisler, Russell, Treasure, & Dodge, 2001) means that guidelines for treatment are tenuous. Accordingly, new approaches showing promise must be developed (Wilson, Grilo & Vitousek, 2007).

Critical-internal dialogues appear to play a role in the maintenance of a range of psychological disorders (Gangdev, 2002; Hepworth, Ashcroft, & Kingdon, 2013) and addressing them has therefore become a target for many evidence-based psychotherapies (Gilbert & Proctor, 2006; Greenberg, 2006). There is preliminary research to suggest that over 90% of ED sufferers describe experiencing an ‘anorexic voice’ (‘AV’; Noordenbos, Aliakbari, & Campbell, 2014; Williams & Reid, 2012).

The ‘AV’ is an internal dialogue which can be distinguished from more typical self-critical cognitions (Higbed & Fox, 2010) or ‘true’ auditory hallucinations (Pugh, 2016). It is usually experienced as a second or third person commentary on thoughts and behaviours relating to eating weight and shape (Tierney & Fox, 2010). The ‘AV’ tends to emerge during the onset of the illness and is often described as providing reassurance at this stage as it facilitates the numbing of distressing emotions (Tierney & Fox, 2010). Over time, however, the ‘AV’ can become hostile and controlling, encouraging increasingly destructive eating behaviours. (Noordenbos, Aliakbari, & Campbell, 2014; Williams & Reid, 2012). In the midst of their illness, many individuals describe feeling entrapped and submissive to their ‘AV’ (Tierney & Fox, 2011). As a result, many individuals struggle to engage in treatments where there is an emphasis on change (e.g. cognitive behavioural therapy), as any attempt to modify eating behaviour is met with internal hostility.

Research indicates that clients desire a greater understanding of the ‘AV’ by professionals (Davies, 2008; Duncan, Sebar, & Lee, 2014) and that interventions which help manage such experiences are both valued and capable of achieving

significant improvements in pathology (Dolhanty & Greenberg, 2009; Mountford & Waller, 2006). Emotion-focused therapy (EFT; Dolhanty & Greenberg, 2007) is an evidence-based (Sala, Heard, & Black, 2016) form of psychological therapy well suited for this work as it offers techniques for dealing explicitly and effectively with the harsh internal critical voice. EFT incorporates an experiential technique called “chairwork”, which we will use to facilitate communication with the anorexic voice in order to encourage more assertive responses to critical-internal voices and reduce the severity of self-attacking.

The therapy is assumed to work to change mood, anxiety and AN symptoms in the following way: Individuals with AN experience increased negative emotions, decreased positive emotions, and deficits in emotion regulation compared to healthy controls, often as a direct consequence of intense self-attacking (manifest as the internal voice). It has long been recognised that these characteristics of AN may play a role in maintaining ED habits as it is thought that engaging in ED behaviours can help (in the short-term) avoid negative emotions and that restrictive eating performs a defensive function in reducing the intensity of self-attacking. It is theorised that working with the AV will be targeting the underlying emotions and that this therapy will help clients increase their emotional awareness, cope with and manage emotions in more adaptive ways, and develop a more affiliative style of self-to-self relating. It is hoped that this will translate into positive changes in eating behaviour.

The overall aim of the treatment is to soften the severity of the voice and encourage the voice to be less demanding and more supportive. Clients will also be encouraged to create a ‘compassionate other’ and to ‘let others in’ to counteract the negative impact of the voice. We hope that this treatment will be a useful foundation for their later treatment, as this brief intervention is being offered as a modular intervention, to fit around current treatment.

In session exercises will be supplemented by weekly homework tasks to maximise the therapeutic effects of in-session interventions and consolidate learning. A rolling homework for clients will be to review audio-recordings of each therapy session.

There is a chance that the frequency/severity of participant’s voices will increase as a result of focusing on it in the intervention. Therefore, participants will be given techniques to manage the voice throughout the intervention (see below).

THE INTERVENTION

Session 1:

The first session will focus on assessment of the ‘AV’: its onset, intensity, frequency, triggers and content will be established.

Clients will be given psycho-education related to the anorexic voice. See handout.

The therapist will focus on therapeutic engagement by focusing on the relationship and rapport between therapist and client. The therapist will attempt to ensure that the client feels safe and validated.

At the end of every session therapist and client will collaboratively write out the 'Main Themes' of the session and the most important take away points.

Homework:

Clients will be strongly encouraged to keep a daily diary for homework that monitors their voice (see 'AV' diary I).

Clients will be asked to review the 'Main Themes' between sessions

Clients will be asked to review the psycho-education handout

Clients will be asked to complete the outcome measures between sessions

Session 2:

The second session will continue to focus on engagement, as above, but also move on to assessing motivation, one's style of relating to the anorexic voice, and its perceived functions. This will be done by conducting a two-chair simulated interview with the anorexic voice:

The participant will be asked to change seats and enact the anorexic voice as best they can. The therapist will then ask them questions such as:

When did you first come into PARTICIPANTS's life?

What were your reasons for becoming a part of PARTICIPANT's life then?

What is your role now?

What are your goals / hopes for PARTICIPANT?

The participant will then be asked to move back to their original chair and asked questions such as:

What was it like to hear anorexia's comments? How do you feel?

Is there anything you would like to ask or say to anorexia?

What do you need from anorexia going forwards?

This exercise is designed to identify participants' ambivalence about their illness and their voice, as well as inform the formulation. The therapist is trying to compare what the participant values with what their voice values, and develop discrepancies between the two.

At the end of the session clients will be given information on detached mindfulness to help cope with potential increased/frequency of the voice. (See handout)

By the end of session 2 the therapist will draw up a dialogical formulation.

Homework:

Outcome measures

Review 'Main Themes'

Practice detached mindfulness

Clients will be asked to write out the pros and cons of living life according to the 'AV' in preparation for the next session

Sessions 3 and 4:

These sessions will focus on more dialogical work with the voice, principally using an evidence-based two-chair technique for self-interruptive splits as developed in EFT (Shahar et al., 2011).

The aim of these sessions is to 'soften' the voice and to start changing participants' relationship with the voice - to develop a stronger sense of self that is able to challenge the voice.

To help resolve the ambivalent relating style most individuals have, the therapist will explore the pros and cons of living life according to the anorexic voice.

The client is first asked to change chairs and enact their 'AV' in the third person ("You are..."). After a period of expression the client is asked to switch seats and express how it feels to receive such attacks.

If the client becomes stuck the therapist can put the 'block' in the chair or enact the healthy voice themselves.

Homework:

Outcome measures

Review 'Main Themes'

Practice detached mindfulness

Clients will be given coping flashcards to use outside of sessions (see handout)

At the end of session 4 clients will be asked to think about a compassionate voice. In preparation for session 5 they will be asked to think about its characteristics and to name it.

Session 5:

The aim of session 5 is to build a more compassionate way of self-to-self relating. The session will focus on finding a soothing voice, dialogue, warm presence to self-soothe, soften the 'AV' and help regulate their emotions.

The client is asked to change chairs and enact their 'compassionate voice' in the third person ("You are..."). After a period of expression the client is asked to switch seats and express how it feels to receive such compassion.

If the client cannot be the compassionate voice, the therapist can be the voice to start with and ask the client to repeat what they are saying.

Homework:

Outcome measures

Review 'Main Themes'

Use flashcards

Practice mindfulness

Clients will be asked to write a 'goodbye letter' to their 'AV'. The therapist will write one to the client.

Session 6:

The aim of session 6 is to bring the work together.

Re-decision dialogues will be used to guide and enhance this exercise.

Clients will be asked to change seats and read their goodbye letter to the 'AV'. They will then be encouraged to further elaborate how the 'AV' has affected their life, their intent to change the relationship and the steps they will take to achieve this.

Homework:

Review handout "Beginning to build a life without the 'AV'"

Outcome measures

Review 'Main Themes'

Use flashcards

Practice mindfulness

Appendix 4
Participant Consent Form

CONSENT FORM
(Participant Copy)



Title of Project: Applying emotion focused therapy (EFT) to work with the 'anorexic voice' ('AV') within anorexia nervosa (AN). A proof of concept study.

Name of Researcher: Rebecca Hibbs

box

Please initial

1. I confirm that I have read and understand the information sheet dated 09/02/17 for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without legal rights being affected.

☐

3. I understand that the information I provide for this study is confidential.

☐

4. I consent to the information I provide being stored securely at King's College, University of London for no longer than 5 years.

☐

5. I agree to take part in the above study.

☐

6. I agree to the researchers informing my GP that I am taking part in the study

☐

Name

Date

Signature

Name of person taking consent

Date

Signature

Thank you for taking part in our research

Version 1 07/03/17
Consent for participants

Appendix 5

Session Handout ('Beginning to Build a Life without the AV')

Building a new life without the anorexic voice

Part One: Building upon the progress you have made

As you come to the end of your treatment, some things about your anorexic voice will have changed and some may have not. Sometimes change takes a while to catch up with you, so don't feel discouraged if you have not gotten as far as you had hoped. It is important to remember that the process of change does not stop at this point: rather, your treatment will form a solid foundation for making even more positive changes in your relationship with the anorexic voice in the future.

What are the most important things you have learnt whilst working with your anorexic voice?

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What are the most important changes you have made and that you want to maintain?

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What are the next steps in further developing your caring and compassionate internal voice?

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What other areas of your life will require further development?

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Building a new life without the anorexic voice

Part Two: Responding positively to setbacks

Changing one's relationship with the anorexic voice is hard. Many individuals find that the voice continues to cause some niggles, doubts and worries at the end treatment. Setbacks are also not unusual – the key is being prepared for situations which might cause difficulties and knowing how to respond in a helpful and proactive way.

Situations which might cause my anorexic voice to come online or become more intense:

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Warning signs that my anorexic voice is causing problems:

Thoughts	
Feelings	
Behaviours	
Physical sensations	

Relationships	
Other areas of life Health Hobbies Etc.	

Healthy ways of coping if my anorexic voice becomes more active:

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<i>Comments that the anorexic voice might make during difficult times.</i>	<i>An alternative response from my compassionate / recovery-focused side</i>

<p>What tricks or tactics might the voice use to reel you in?</p>	<p>What would you say to a loved one if they were told this? How could you think about this situation with warmth, care and self-acceptance?</p>
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Key statements to hold on to from my compassionate internal voice during difficult times:

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Appendix 6

Session Handout ('Detached Mindfulness')

Adapted from Cooper, Todd & Wells (2009). Treating bulimia nervosa and bulimia nervosa: An integrated metacognitive model and cognitive therapy manual. London: Routledge.

Adapted from Harris, R. (2008). The happiness trap. London: Robinson.

What is detached mindfulness?

Detached mindfulness (DM) helps individuals develop a new relationship with their internal experiences, including the anorexic voice. Instead of 'engaging' with the anorexic voice, DM encourages us to observe it in a detached way, without attempting to interpret, analysis, control, react or adjust one's behaviour in response. This can help individuals develop a more helpful way of relating to the voice; one which causes less emotional pain and problematic behaviours.

An example of detached mindfulness

Let's try an example: To help you practice DM, close your eyes for a moment and bring to mind an image of a real-life cat. Don't try to influence or change the cat's behaviour. Just watch it. See what it does. Observe how it behaves. It may move, it may blink, it may not. It may change, but don't make it change. Just watch how the image develops over time. Watch it in a passive way.

What did you notice?

What was your experience of your image?

Did you notice how you could step back from the image of the cat and observe it from distance, all while you were not influencing or forcing it's behaviour in any way?

This is detached mindfulness: stepping back and observing our inner experiences non-judgementally. It is about becoming aware of our inner experiences without any attempt to avoid, control or suppress those experiences.

Detached mindfulness and the internal anorexic voice

When you start to hear your internal anorexic voice, try to be aware of the triggering situation and the thoughts and feeling preceding the voice. Acknowledge to yourself that the voice is occurring and remind yourself that engaging with it is unhelpful. Some people find it useful to say to themselves: 'This is just my internal anorexic voice. Such thoughts do not necessarily represent the facts. I don't need to do anything about this thought or voice. I am going to leave it alone. I'm not going to worry about it, focus on it, or do anything about it. I don't need to react in any way'.

Remember that engagement with the anorexic voice includes arguing back, negotiating with it, worrying or dwelling on it. It includes trying to control the voice or avoid it. Most importantly, it includes responding to the voice by restricting, binge-eating or vomiting. Try

to let the anorexic voice and your associated thoughts occupy their own space and time, without engaging with them.

Some analogies

One way of thinking about the anorexic voice (and other thoughts) is imaging it is a bit like a radio (“Anorexia FM”), playing in the background. The presenter might remind you of bad things from the past, scary things in the future or provide updates on what is wrong with you. But have you ever had a radio playing in the background but been so intent on what you are doing that you didn’t really listen to it? The same goes for the anorexic voice. When it speaks to you, you can acknowledge it, observe what it says, and turn your attention to what you are doing in the here-and-now. Remember: you are not trying to ignore, suppress or dispute what the DJ is saying. Rather you are simply letting these thoughts come and go in the background, without needing to engage with them.

Alternatively, you could imagine the voice’s statements as being like clouds in the sky: they will pass you by without any need to stop them or push them away. In fact, trying to do so is impossible. Try to step back and observe such thoughts as clouds, merely drifting by.

Lastly, you might image that the voice’s statements are like leaves on stream: you can step back and, from the river bank, observe its comments float by you and down the stream. You do not need to react, fight or avoid these thoughts in any way. You can just watch them, non-judgementally and with acceptance, and without a need to respond.

Appendix 7

Session Handout ('Coping Flashcards')

My Anorexic Voice Flashcard

Right now I am really struggling with my internal anorexic voice.

The situations which tend to trigger my internal anorexic voice include (TRIGGER SITUATIONS):

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.....

The things my voice tends to say to me in situations like these are (ANOREXIC VOICE STATEMENTS):

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When the voice speaks to me in this way, I usually feel (PAINFUL EMOTIONS):

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When I think and feel this way, I might want to (or the voice might want me to) (MALADAPTIVE BEHAVIOUR):

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Whilst my anorexic voice might seem true and/or helpful right now, what I need to remember is (COPING STATEMENTS, PSYCHOEDUCATION, COUNTER-EVIDENCE, LONG-TERM CONSEQUENCES):

.....

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Remembering this will help me to feel (ADAPTIVE EMOTION):

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Therefore, instead of listening to the anorexic voice and acting on what it says, I could instead (ADAPTIVE COPING BEHAVIOUR):

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Appendix 8

The EDE-Q (Fairburn & Beglin, 1994)

Content removed for copyright reasons.

Appendix 9

The HADS (Zigmond & Snaith, 1983)

Content removed for copyright reasons.

Appendix 10

The P-CAN (Serpell et al., 2004)

Content removed for copyright reasons.

Appendix 11

The EAVE-Q, Gant et al. (2018)

Content removed for copyright reasons.

Appendix 12

The Brief IPQ (Broadbent et al., 2006)

Content removed for copyright reasons.

Appendix 13

The ED-15 (Tatham et al., 2015)

Content removed for copyright reasons.

Appendix 14

Follow-up interview schedule

Follow-up interview schedule

1. Overall, how did you experience the intervention?
2. How well do you identify with an anorexic voice: was it something you identified with at the start of treatment and how do you feel about it now?
3. What was it like working directly with your anorexic voice?
4. What was it like speaking with your voice during the intervention?
5. How did you find using chairwork?
6. Since starting the intervention, what has changed and what has stayed the same for you?
7. What has changed and what has stayed the same in terms of your anorexic voice?
8. Overall, what have you taken away from intervention?
9. What did you value most about the intervention?
10. How do you think the intervention might be changed or improved?

Appendix 15
National HRA Approval Document



Dr Rebecca Hibbs
Camden and Islington NHS Foundation Trust
Royal Holloway, University of London
Egham, Surrey
E3 5LD

Email: hra.approval@nhs.net

29 June 2017

Dear Dr Hibbs

Letter of HRA Approval

Study title:	Applying emotion focused therapy (EFT) to work with the 'anorexic voice' ('AV') within anorexia nervosa (AN). A proof of concept study.
IRAS project ID:	219549
REC reference:	17/LO/0775
Sponsor	Royal Holloway, University of London

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	219549
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procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is 219549. Please quote this on all correspondence.

Yours sincerely

Joanna Ho
Assessor

Email: hra.approval@nhs.net

Copy to: *Mrs Annette Lock, Sponsor Representative, Royal Holloway, University of London*
Mr Nevan McNichol, Lead NHS R&D Contact, Noclur Research Support
Dr John Fox, Academic Supervisor, Cardiff University

Appendix 16

Non-substantial amendment

From: AMENDMENTS, Hra (HEALTH RESEARCH AUTHORITY)
Sent: 09 October 2017 11:08
To: rebecca.hibbs.2015@live.rhul.ac.uk
Cc: annette.lock@rhul.ac.uk; NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)
Subject: IRAS 219549 Amendment Categorisation and Implementation Information

Amendment Categorisation and Implementation Information

Dear Bex

Thank you for submitting an amendment to your project.

If you have participating NHS/HSC organisations in any other UK nations that are affected by this amendment we will forward the information to the relevant national coordinating function(s).

Please note that you may only implement changes described in the amendment notice.

What Happens Next?

Information Specific to Participating NHS Organisations in England

1. This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA.
2. You may implement this amendment immediately.
3. You should ensure that participating NHS organisations in England are informed of this amendment. In doing so, you should include the NHS [R&D Office](#), [LCRN](#) (where applicable) as well as the local research team.
4. Participating NHS organisations in England should prepare to implement this amendment, where expected.

IRAS Project ID:	219549
Short Study Title:	Using EFT to work with the anorexic voice
Date complete amendment submission received:	2 October 2017
Sponsor Amendment Reference Number:	1 (AM01)
Sponsor Amendment Date:	1 October 2017
Amendment Type	Non Substantial
Outcome of HRA Assessment	This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA.

For NHS/HSC R&D Office information	
Amendment Category	C

If you have any questions relating to the wider HRA approval process, please direct these to hra.approval@nhs.net

If you have any questions relating this amendment in one of the devolved administrations, please direct these to the relevant [national coordinating function](#).

Additional information on the management of amendments can be found in the [IRAS guidance](#).

Please do not hesitate to contact me if you require further information.

Kind regards

Kirsten



Kirsten Peck
HRA Approval Amendment Coordinator
Health Research Authority
 Level 3
 Block B
 Whitefriars
 Lewins Mead
 Bristol
 BS1 2NT
 T. 02071048051
 E. kirsten.peck@nhs.net
 W. www.hra.nhs.uk

IMPORTANT – [Click here](#) for the latest details of the roll-out of HRA Approval in England

The HRA is keen to know your views on the service you received – our short feedback form is available [here](#)

Appendix 17
First Substantial amendment



London - Bloomsbury Research Ethics Committee

HRA RES Centre Manchester
Barlow House 3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8002

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

13 November 2017

Dr Rebecca Hibbs
6 Wrights Road
E3 5LD

Dear Dr Hibbs

Study title:	Applying emotion focused therapy (EFT) to work with the 'anorexic voice' ('AV') within anorexia nervosa (AN). A proof of concept study.
REC reference:	17/LO/0775
Amendment number:	Substantial Amendment 1
Amendment date:	10 October 2017
IRAS project ID:	219549

The above amendment was reviewed the Sub-Committee in correspondence.

Ethical opinion

Approval was sought for a change in the inclusion criteria – the researchers now wish to broaden the inclusion criteria to include atypical anorexia nervosa and any episode.
There were no ethical issues raised.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)	Substantial Amendment 1	10 October 2017
Research protocol or project proposal	3	11 October 2017

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

17/LO/0775:	Please quote this number on all correspondence
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Yours sincerely



On behalf of
Reverend Jim Linthicum
Chair

E-mail: nrescommittee.london-bloomsbury@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mr Nevan McNichol,
Noclor Research Support

London - Bloomsbury Research Ethics Committee

Attendance at Sub-Committee of the REC meeting

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Reverend Jim Linthicum Chair	Hospital Chaplain	Yes	
Dr Ruth Williams	Consultant Paediatric Neurologist	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Ewa Grzegorska	REC Assistant

Appendix 18
Second Substantial Amendment



London - Bloomsbury Research Ethics Committee

HRA RES Centre Manchester
Barlow House 3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8198

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

28 February 2018

Dr Rebecca Hibbs
6 Wrights Road
E3 5LD

Dear Dr Hibbs

Study title:	Applying emotion focused therapy (EFT) to work with the 'anorexic voice' ('AV') within anorexia nervosa (AN). A proof of concept study.
REC reference:	17/LO/0775
Amendment number:	2
Amendment date:	08 February 2018
IRAS project ID:	219549

The above amendment was reviewed at the meeting of the Sub-Committee held on 23 February 2018.

Summary

The purpose of the amendment is to notify the Committee of a request to conduct a follow-up interview, which is made up of 10 questions about how clients felt about the intervention.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee raised no ethical issues with this amendment.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)	2	08 February 2018
Other [Follow up interview schedule]	1	08 February 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

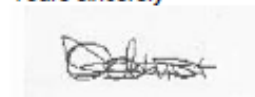
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

17/LO/0775:	Please quote this number on all correspondence
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Yours sincerely



Signed on behalf of;
Reverend Jim Linthicum
Chair

E-mail: nrescommittee.london-bloomsbury@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mr Nevan McNichol, Noclor Research Support

London - Bloomsbury Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 23 February 2018

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Paul Gorczynski	Chartered Psychologist	Yes	Vice chair
Ms Cathy MacLean	Clinical Project Manager	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Ewa Grzegorska	REC Manager
Miss Damilola Odunlami	REC Assistant

Appendix 19

Empathy Scale (Truax & Carkhuff, 1967)

Content removed for copyright reasons.

Adapted Adherence Measure for Two-Chair Dialogues

Two chair dialogue for conflict splits
<i>Does the therapist....</i>
Help the client to clearly separate the two opposed aspects of the self?
Create contact between the client's two opposed aspects of self?
Promote awareness and differentiation of a coercive or critical aspect of the self and what it is doing to the other part of the self?
Help the client become aware of deeper feelings in reaction to the critical self?
Focus the client on the inner feelings/values/needs underlying the self-criticism?
Encourage the declaration of the wants and needs of the self that emerge from newly emerged feelings?
Promote negotiation or integration between different aspects of self?
Key:
0 = absence of feature, or highly inappropriate performance
1 = inappropriate performance, with major problems evident
2 = evidence of competence, but numerous problems and lack of consistency
3 = competent, but some problems and/or inconsistencies
4 = good features, but minor problems and/or inconsistencies
5 = very good features, minimal problems and/or inconsistencies
6 = excellent performance, even in the face of patient difficulties